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Introduction

The District of Columbia's HIV Prevention Community Planning Committee (HPCPC) is charged with identifying the potential strategies and interventions that are most appropriate to prevent new HIV infections within the high-risk populations identified through the prioritization process. This section describes primary prevention strategies and interventions that have been used with different populations.

Two assumptions underlie this description of strategies for primary prevention interventions. [The Centers for Disease Control and Prevention (CDC) defines primary prevention as "halting the transmission or acquisition of HIV infection" and secondary prevention as "halting or delaying the onset of illness in an HIV infected individual."]

First, while any intervention can be delivered either by a non-peer professional or by a trained peer, available data suggest that peer-based interventions are superior for achieving behavior change. Second, all forms of HIV prevention will be more effective if they are culturally, socially, and linguistically appropriate to the populations they are designed to serve. (1)

Two criteria should be considered in choosing interventions:

1. Prevention interventions should be supported by sound evidence that they produce behavior change that results in a lowered risk of acquiring or transmitting HIV. (Information on the effectiveness of interventions can be found on **Page 4.27**)
2. In the absence of such evidence, prevention interventions should be supported by compelling arguments that they are likely to be successful at reducing HIV risk. These arguments should be based on behavior-change theory with a sensible rationale that appropriate and relevant behavior change could be produced. (An article describing the use of theory in HIV prevention interventions can be found on **Page 4.79**)

A Caveat

This section describes several programs that have been successful with different populations, and CBOs may be interested in adapting or adopting those programs for their own target populations. Adopting HIV/AIDS interventions that have been effective in other settings can reduce start-up time and resources.

But program adoption is not as simple as moving an intervention from one environment to another. A program designed to work with a Black population may not work with a Hispanic/Latino population. The program that is being adopted may have to be modified to address different cultural, linguistic and comprehension levels, as well as different communication patterns.

A critical factor for program success whenever a program is adopted is "buy-in" from the target population, which should be involved in the design and implementation of any HIV prevention intervention. In addition, any new program should be pilot-tested before it is fully implemented.

Cost Effectiveness

Information on the cost effectiveness of several interventions can be found on **Page 4.75.** But there are no cost-effectiveness studies for some interventions.

In general terms, you can compare the cost of an intervention that can prevent one or more cases of HIV infection against the cost of one case of infection. The lifetime medical cost of treating a person infected with HIV is estimated at $119,000. (2) One thousand dollars spent on HIV prevention can save $2,700, depending on the HIV prevalence in the targeted population. (3)

Prevention interventions targeted to high-risk populations have a greater effect on the number of HIV infections prevented. One way to assess this is to compare the number of HIV infections likely to be prevented over five years in a program that reduces risk behaviors by a modest 10%. In populations with HIV prevalences of 10%-15% (men who have sex with men in the District of Columbia), $1 million will prevent about 100 infections. In populations with HIV prevalence of about 1% (Hispanic/Latina women in the District), $1 million will prevent about 15 infections. In the large portion of the US population at very low risk, with 0.1% prevalence, about two infections would be prevented. (3)

In the District of Columbia, studies and estimates show that HIV prevalence ranges from a low of 0.2% among white women to a high of 27% for Black male injecting drug users attending an STD clinic. The 1999 Epidemiologic Profile of the District of Columbia was the source of information on HIV prevalence in four populations:

Population	**HIV prevalence**
Black male IDUs attending an STD clinic	27%
White male IDUs attending an STD clinic	15%
Hispanic male IDUs attending an STD clinic	11%
MSM attending an STD clinic	15%

The following prevalence rates were estimated by dividing the estimated number of individuals from each population who are living with HIV (from the Epidemiologic Profile) by the US Census Bureau estimates of the adult/adolescent population in DC as of 1997.

Population	**HIV prevalence**
White women	0.2%
White men	3.4%
Black women	1.7%
Black men	6%
Asian and Pacific Islanders and Native Americans	0.8%
Hispanic/Latina women	1%
Hispanic/Latino Men	8.9%

Successful prevention programs that are already well established often show decreased risk behavior and HIV prevalence (e.g. efforts aimed at older gay/bisexual men). This does not indicate that prevention funds would be better used elsewhere; these programs need to be maintained so that new HIV infections do not recur. (4)

Intervention Types

In 1999 the Centers for Disease Control and Prevention (CDC) identified the types of standardized evaluation data it needs to be accountable for in its use of federal funds and to conduct systematic analysis of HIV prevention, to improve HIV prevention policies and programs. Evaluation data that are needed include the types and quality of HIV prevention interventions provided by CDC health department grantees and their grantees, the characteristics of clients targeted and reached by the interventions, and the effects of interventions on client behavior and HIV transmission.

The CDC evaluation guidance and data system defines intervention as "...a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular risk population using a common method of delivering the prevention messages. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation."

The CDC has requested that health departments – including the Administration for HIV/AIDS – provide aggregate data from their jurisdiction for each of the seven types of interventions covered by the evaluation guidance for each risk population (defined as a risk exposure category). In order to be able to comply with this request, AHA has adopted the CDC definitions of intervention types.

The seven types of interventions identified by the CDC in its guidance on evaluation are: individual-level interventions, group-level interventions, outreach, prevention case management, partner counseling and referral services, health communications/public information, and other interventions.

Descriptions of Interventions

Individual-level Interventions (ILI) consist of health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.

According to a strict categorization, outreach and prevention case management also are individual-level interventions. However, for the purposes of evaluation reporting, ILI does *not* include outreach or prevention case management, each of which constitute their own intervention categories.

An example of ILI is individual prevention counseling, the purpose of which is to provide one-time counseling and health education interventions to persons who are at high risk for HIV infection, to promote and reinforce safe behavior. This type of counseling -- which is not linked with HIV antibody testing -- provides education and counseling at sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers, social service offices, or medical clinics. Individual prevention counseling may be delivered by peers or non-peers.

Group-level Interventions (GLIs) consist of health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide-range of skills, information, education, and support.

Many providers may consider general education activities to be group-level interventions. However, for the purposes of CDC reporting, GLI does *not* include "one-shot" educational presentations or lectures that lack a skills component.

Interventions that focus on groups as a target for HIV prevention and education may be structured to encourage the initiation and maintenance of safer behaviors, to provide interpersonal skills training, and/or to sustain appropriate behavior change. As with individual counseling, the intervention may be delivered by a peer or a non-peer, and programs usually include information about condom use, negotiation of safer sexual behaviors and risk-reduction strategies for IDUs. Unlike CTRPN and individual interventions, group interventions may target those at low risk for HIV/AIDS as well as those at high risk. An example of group-level interventions is psycho-educational skills-building groups.

Outreach interventions are generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate (e.g. bars, parks, shooting galleries). Outreach usually includes distribution of condoms, barriers, bleach and educational materials. Includes peer opinion leader models.

Street outreach programs aim to encounter clients in their own community who are unlikely to be receiving important HIV prevention services. This strategy usually targets individuals at informal sites where persons engaged in high-risk activities congregate and includes the distribution of condoms, bleaching kits and literature. Outreach workers -- who may be trained peers or non-peers -- also provide referrals to prevention, substance abuse or early intervention programs.

Needle exchange programs are a form of outreach intervention used to reduce the transmission of HIV among injecting drug users, their sex partners, and their children. They provide new, sterile syringes in exchange for used, contaminated syringes. Many needle exchange programs also provide drug users with a referral to drug counseling and treatment, medical services, and provide risk reduction information. Federal funds can not be used for needle exchange programs, and Congress has prohibited the use of District of Columbia funds for needle exchange programs.

Prevention Case Management (PCM): This is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV risk-reduction counseling and traditional case management. It provides an ongoing, sustained relationship with the client in order to assure multiple-session, individualized HIV risk reduction counseling that provides intensive, support, and referrals to other services.

The goal of PCM is to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are HIV-positive. PCM is intended for persons who are having or who are likely to have difficulty initiating and sustaining safer behavior.

Case managers work with clients to assess their HIV risk and psychosocial and medical needs, develop a plan for meeting those needs, facilitate the implementation of the PCM plan through referral and follow-up, provide ongoing HIV risk-reduction counseling, and advocate on behalf of the client to obtain services. Referral services may include HIV counseling and testing services (CT), psychosocial assessment and care, other HIV health education and risk reduction programs, medical evaluation and treatment, legal assistance, substance abuse treatment, crisis intervention, and housing and food assistance.

Partner Counseling and Referral Services (PCRS) provides a systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Counseling and testing refers to the voluntary process of HIV testing accompanied by client-centered, interactive information-sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, and how to prevent the transmission and acquisition of HIV infection. In the best of situations, the individual also receives tailored support on how to adapt this information to his or her life.

Referral is the process by which individuals with high-risk behaviors and those infected with HIV are guided towards prevention, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs.

Voluntary partner notification is the voluntary process by which sex and needle-sharing partners of a person who is either HIV positive or at high-risk for HIV are located, informed of their possible risk, and encouraged to seek counseling and testing for themselves.

Health Communications/ Public Information (HC/PI): The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services.

Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience.

Print Media: These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage.

Hotline: Telephone service (local or toll-free) offering up-to-date information on HIV/AIDS and referral to local services, e.g., counseling/testing and support groups.

Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide information to the general public as well as high-risk populations.

Presentations/Lectures: These are information-only activities conducted in group settings; often called “one-shot” education interventions. Workshops and presentations are typical activities of community outreach. Because they usually follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. While they supply important opportunities to disseminate HIV/AIDS prevention information, their impact on behavior change is limited because they are usually single-encounter experiences. Although they provide crucial information that raises awareness and increases knowledge and may be a critical first step in the change process, the information alone is usually inadequate to sustain behavior change.

One examples of this type of activity is **Community Workshops and Presentations**, which are one-shot activities in which participants are provided with basic information on HIV/AIDS.

Other Interventions: This category is used for those interventions that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilization, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Community-level interventions are those that:

(a) target the community (often defined by gender, geography, risky behaviors, race, ethnicity, or sexual orientation) rather than a specific individual;

(b) involve community members in the actual design and delivery of the intervention; and

(c) aim to change community norms about high-risk behaviors (as well as modify individual behaviors)" (Holtgrave et al., 1994).

Programs in this category may use multiple methods in order to influence community norms. These include social marketing (the application of marketing theory and strategies to the promotion of social change), community-based outreach (e.g., using indigenous community members to disseminate information), mass media (television, radio, newspapers, billboards), and small media (newsletters, posters, flyers).

One example of CLI is **Community Mobilization,** the goal of which is to increase awareness and knowledge of HIV/AIDS issues and to provide a foundation for the greater participation of people in general in HIV prevention and service activities. This intervention generally targets persons who are not at risk for HIV/AIDS as well as those who are at risk.

Furthermore, community mobilization may not be designed to change individual health behavior; rather, it aims to create a social, political, and institutional climate that is receptive to the development and implementation of effective prevention programs.

An example of Community Mobilization is worksite-based informational seminars designed to dispel myths about HIV/AIDS. This correction of misconceptions may be intended to reduce discrimination against HIV-positive persons or persons whose lifestyle places them at risk for HIV. Another example is that of educational materials directed at parents and members of school boards, the objective of which is to create an environment within which school-based risk-reduction information might be facilitated.

References

1. The bulk of this material is taken from the CDC guidance – Evaluating CDC-Funded Health Department HIV Prevention programs – and from a chapter prepared for the Plan for the Prevention of HIV in Orange County CA, 1996-99, by Nancy H. Corby, Ph.D., and Margaret Schneider Jamner, Ph.D., from the Center for Behavioral Research and Services, California State University, Long Beach. Other sources include the 1998 District of Columbia funding application to the CDC; several Requests for Proposals issued by the Administration for HIV/AIDS in 1998; the 1997 San Francisco HIV Prevention Plan, and the Los Angeles County HIV Prevention Plan for 1996-99.
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Population-Specific Interventions

Excerpted from Section 2 of the Prevention Plan: Population-Specific Prevention Needs

This section contains information on interventions that have been successfully implemented or are recommended for different populations. Although this document identifies at-risk individuals by groups such as age, gender, sexual orientation and race/ethnicity, it should be clear that those factors do not place individuals at risk of infection. It is their behavior that may increase their risk, and it is these behaviors – and the causes for these behaviors – that are the intended focus of all prevention efforts.

Adolescents and Young Adults

Adolescents appear to change their behavior only if they receive repeated and consistent prevention messages; if they have the opportunity to develop the skills necessary to change their behavior; and if they have support for change from individuals and groups whom they can trust or identify with. (4)

HIV prevention programs for adolescents must consider the developmental needs and abilities of this age group. Programs should focus on contextual factors that lead young people to engage in higher rates of sexual activity and lower rates of condom use, such as low self-esteem, depression, substance use, gang activity, stress of living in turbulent urban environments, or boredom/restlessness related to unemployment. (2)

Any program for adolescents should be interesting, fun and interactive, and involve youth in the planning and implementation. This is especially true for out-of-the-mainstream youth and youth from diverse cultures. Programs for hard-to-reach youth who are most at risk for HIV infection should be implemented in venues outside of schools, such as runaway/homeless youth shelters, shopping malls, detention facilities and recreation/community centers. Adolescents not only need correct information and practice in self-protective skills, but also easy access to condoms in order to keep themselves risk-free. (2)

Participants in the HPCPC-sponsored focus group recommended that more outreach workers be used throughout the community, to provide education and distribute free condoms, “especially” because most youth would not make special efforts to go to clinics for the help they need in order to prevent contracting HIV. (3)

The Center for Disease Control and Prevention recommends the implementation of a wide range of activities: (1)

School-based programs. Because risk behaviors do not exist independently - for example, a young person's ability to resist peer pressure and social influences to smoke are integrally related to the ability to say no to risky sexual activity - topics such as HIV, STDs, unintended pregnancy, tobacco, nutrition and physical activity should be integrated and ongoing for all students in kindergarten through high school. Research has clearly shown that the most effective programs are comprehensive ones that include a focus on delaying sexual behavior and provide information on how sexually active young people can protect themselves.

Community-based programs. Addressing the needs of adolescents who are most vulnerable to HIV infection, such as homeless or runaway youth, juvenile offenders, or school dropouts, is critically important. Community **outreach** programs play an important role in reaching these young people.

Sustaining prevention efforts for young gay and bisexual men. Targeted, sustained prevention efforts are urgently needed for young MSM as they come of age and initiate high-risk sexual behavior. Ongoing studies show that both HIV prevalence and risk behaviors remain high among young MSM. In a sample of young MSM ages 15-22 in 6 urban counties, researchers found that, overall, between 5% and 8% were infected with HIV. HIV prevalence was higher among young African-Americans (13%) and Hispanics (5%) compared with young white MSM (4%).

Need to address sexual and drug-related risk. Many students report using alcohol or drugs when they have sex, and 1 in 50 high school students reports having injected an illegal drug. Surveillance data from the 25 states with integrated HIV and AIDS reporting systems between January 1994 and June 1997 showed that drug injection led to 6% of HIV diagnoses reported among those aged 13-24 during that time period, with an additional 57% attributed to sexual transmission (26% heterosexual, 31% from male-to-male sex).

Role of STD treatment in comprehensive HIV prevention programs for young people. An estimated 12 million cases of STDs other than HIV are diagnosed annually in the United States, and about two-thirds (roughly 8 million) of those are among people under the age of 25. A large body of research has shown that biological factors make people who are infected with an STD more likely to become infected with HIV if exposed sexually; and HIV-infected people with STDs also are more likely to transmit HIV to their sex partners. Expanding STD treatment services is critical to reduce the consequences of these diseases and to help reduce the risks of transmitting HIV among youth.

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African-Americans

Not many prevention programs specific to African-Americans have been evaluated for effectiveness, but the number of programs is increasing and there are a few promising studies. (1) An intervention aimed at African-American gay and bisexual men extensively pilot tested all materials including videos that depicted only black men and addressed issues related to the men's same-sex attitudes and behaviors addressed in their own words. Clients who participated in three weekly, three-hour group sessions greatly reduced (50%) their frequency of unprotected anal intercourse, and maintained the behavior change through an 18-month follow-up. (2)

African-American male adolescents in Philadelphia, PA took part in an intervention to increase knowledge of AIDS and sexually transmitted diseases (STDs) and weaken problematic attitudes towards risky sexual behaviors. Educational materials included a video narrated by a black woman with a multiethnic cast and "AIDS basketball" where teams earned points for correctly answering AIDS questions. Participants reported less sexual intercourse, fewer partners, and greater use of condoms after the intervention. (3)

Men and women attending an STD clinic in the South Bronx, NY had access to either a video on condom use, or both the video and an interactive group session. Patients were given coupons for free condoms at a pharmacy several blocks from the clinic. Among African-American clients, condom acquisition increased substantially after the video and group session, but not after the video alone. One reason may be that the video primarily targeted behavior change among men. Also, clients who self-identified as Caribbean had lived in the US for a shorter amount of time, and the video may have been embedded in US culture. This study showed that interactive sessions combined with videos can personalize the prevention message and enhance behavior change. (4)

In the second decade of the AIDS epidemic, few studies of HIV prevention interventions specifically for African-Americans have been conducted or published. (5) Especially lacking are studies of African-American IDUs and gay/bisexual men. (6)

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African-American Women

A 1996 study in Virginia on HIV prevention for African-American women found that AIDS information and street outreach for this population is most effective when introduced by another African-American woman. The study also found that church support, participation from key community leaders, and women living with HIV/AIDS is critical in educating this hard to reach population. (1)

Preliminary results from a 1998 study on the impact of a six-session AIDS prevention intervention for low-income inner city African-American women in Illinois found "significant

effects" across time for positive attitudes about condom use, knowledge of condom use, self-efficacy to stick to a decision to use condoms, and increased low-risk AIDS behavior. (2) It also found that culturally-specific AIDS prevention interventions based on social learning theory and taught by peer leaders are helpful in promoting attitudes and behaviors conducive to the reduction of HIV/AIDS.

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Chronically Mentally Ill

A review of literature on HIV prevention interventions for this population showed that intensive, small-group interventions that target a variety of risk-related dimensions-including knowledge, attitudes, and motivations, and behavioral and cognitive skills-can produce at least short-term reductions in high-risk sexual behavior among the severely mentally ill. The review also identified several gaps in the research literature, including the need to: (a) better tailor interventions to risk situations encountered by the mentally ill; (b) develop gender-tailored interventions; (c) examine and implement HIV prevention programs so they help persons sustain behavior change; (d) explore one-on-one counseling and community-level intervention methods; and (e) develop risk reduction interventions for already-seropositive individuals. (1)

In a Milwaukee study, 27 men and 25 women were randomly assigned either to a four-session AIDS prevention program emphasizing risk education, sexual assertiveness, condom use, risk-related behavioral self-management, and problem-solving skills or to a waiting-list group, who later received the same intervention. Compared with the waiting-list control group, participants in the prevention program demonstrated significant gains in AIDS-related knowledge and intentions to change risk behaviors. (2)

The prevention program also significantly reduced rates of unprotected sexual intercourse and increased the use of condoms over a one-month follow-up period. A subset of participants who provided two-month follow-up data maintained some behavior change. (2)

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Commercial Sex Workers

The California Prostitutes' Education Project (CAL-PEP) provides condoms, STD/HIV testing, AIDS education and drug treatment referral through regular and repeated street outreach. Outreach workers are former prostitutes who are trained in AIDS prevention. The project successfully encouraged prostitutes to use condoms regularly on the job but found it difficult to influence condom use in private relationships. (1)

On the Streets Mobile Unit-Options in New York City, NY runs vans that bring over 4,000 street prostitutes friendship, food, clothes, condoms, HIV/STD testing and counseling and needle exchange. They also help prostitutes get public assistance and/or drug treatment. Rates of HIV infection among clients have declined since 1989. (2)

The Threshold Project in Seattle, WA helps homeless youth acquire the skills necessary to live independently without sex work. Most of the clients in this program had been emotionally, physically, or sexually abused. The two-year program offered a series of progressively more independent living experiences, and in follow-up, 42% of participants remained in stable living situations without sex work. (3)

When free methadone maintenance was offered to heroin-addicted street prostitutes in southern California, most enrolled. After one year, personal income from prostitution and other crime was reduced 58% and income from legal sources increased 86%. (4)

Internationally, many HIV prevention efforts aimed at sex workers have addressed structural and policy considerations. In Thailand, the Ministry of Public Health began a 100% condom-use program in all sex establishments in several provinces. After the intervention in Samut Sakhon province, the number of condoms used increased from 15,000 to 50,000 a month, and STD incidence decreased from 13% to 0.3-0.5%. (5)

In Bulawayo, Zimbabwe a multiplicity of approaches reached sex workers and clients. AIDS training targeted nurses and health care professionals, as well as non-conventional audiences such as hotel and bar workers and taxi drivers. Community outreach relied on sex worker and client peer educators and provided widespread condom distribution. STD services in the city were also strengthened. (6)

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Deaf and Hearing Impaired

Efforts have been made to reach the deaf community through targeted HIV/AIDS education, but some findings indicate that D&HI individuals, many of whom are isolated from hearing communities due to linguistic and cultural distinctions, may not be completely receiving the messages. Studies show that deaf adolescents have large information gaps concerning HIV transmission and prevention. (1) A 1993 study in Colorado found important gaps in adolescents' knowledge of how HIV and AIDS are transmitted and prevented and who can get HIV. (3)

The particular barriers that the deaf must face in learning about HIV protection range from inadequate schooling about human sexuality to the scarcity of locally available education programs. (2) In Colombia, a 1996 study found that D&HI individuals do not have access to HIV prevention information in the media or educational brochures because 95% of them are illiterate. As a result of the study, the National AIDS Program is developing a mass media campaign that uses sign language to decrease the isolation and lack of communication of the D&HI. (4)

A 1998 study in Cincinnati among persons whose primary language is American Sign Language found that participants were less likely to associate sexual contact with drug users and number of sexual partners as high-risk sexual behaviors. They also believed they did not need to change their sexual behavior as a result of the AIDS epidemic. The study also found differences in receiving, trusting, and/or being exposed to current information about AIDS, consistent with the fact that they are a minority population with distinct knowledge and cultural traditions. (5)

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Gay/Bisexual Men

HIV prevention programs using small group counseling, community outreach, community mobilization, stress reduction counseling, peer education, and skills training have been effective

among all segments of MSM: men in epicenter cities, men in rural communities, young men, adolescents, men of color, and bisexual men. (1)

AIDS education led by peers on a community level is effective at reaching higher-risk men. In several medium-sized towns, the most popular people in social settings were trained to deliver AIDS risk-reduction messages to their friends and acquaintances in gay bars. As a result, fewer men practiced unprotected sex. (2)

The STOP AIDS Project, which grew out of focus groups conducted early in the epidemic in San Francisco, CA, uses community outreach and small group counseling to reduce HIV risk. About 8,000 men are reached annually and about 1,800 attend workshops. Self-reported rates of unprotected anal intercourse declined after the workshops, from 25.1% to 19.4%, with even greater differences among HIV positive men. (1)

Prevention efforts should use a variety of strategies that increase resolve to survive the epidemic, including building self-esteem, strengthening ties to the community, building a future and creating a stronger identify for the community apart from the epidemic. (3)

Institutions within the lesbian and gay community and the larger society must recognize that combating homophobia makes a direct contribution to HIV prevention and redouble efforts to address the civil rights issues of gay and bisexual men.

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Asian & Pacific-Islander Gay/Bisexual Men

Effective HIV prevention and education programs for A&PIs can use many culturally appropriate strategies. For marginalized A&PI populations such as A&PI gay men, peer-based programs are important. Interventions that include the development of nonverbal and other more indirect communication skills also are more culturally appropriate. Outreach activities can be conducted at cultural events, bars, churches and temples, beauty parlors and massage parlors. (1)

One prevention program in San Francisco, CA used culturally tailored brief group counseling to reduce HIV risk among A&PI MSM. The project fostered positive ethnic and sexual identities by addressing topics such as having dual identities, community, racism and homophobia, and practiced eroticizing and negotiating safer sex. Men who participated became more knowledgeable and more concerned about HIV infection, and reported fewer sexual partners. Chinese and Filipino men reported reductions in unprotected anal intercourse. (2)

Participants in the DC study identified several issues that should be included in prevention programs for gay A&PIs, including workshops on risk assessment, safer-sex negotiating skills, and self-esteem. (3) The report on this study also identified a need for "culturally sensitive coming

out tools and/or resources that will address the issues of being queer alongside cultural issues about being Asian or Pacific Islander."

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Hispanic/Latino Gay/Bisexual Men

The Salud needs assessment found a need for prevention interventions that address the self-perception of risk, self-esteem, self-worth, relapse prevention and negotiation skills. Individuals need to have a more concrete idea of how to measure their own individual risk and what steps to take to avoid that risk. This must be carried out through comprehensive interventions that raise the issues of sexual behavior and risk individually. At the same time, the intervention must provide skills to address self-esteem and self-efficacy of participants, so they can effectively take those steps necessary to reduce their level of risk. (1)

The study also found a need for innovative efforts to reach the population. The length of time and the different methods that had to be used to recruit participants for the assessment demonstrated the difficulties in reaching this population. Recruitment through fliers and newspaper advertisements was not effective in accessing the population and street outreach was only moderately successful at one location where gay and bisexual Latino men congregate. Any interventions must be grounded in and have extensive contacts within the community, and include active participation of the stakeholders in the community, in particular community activists.

Surveys respondents and most participants in a community forum also indicated most they did not know what types of resources are available to learn about HIV prevention. Although most respondents indicated that they are very concerned about HIV, they could not describe any institutional source they accessed to obtain information. They also stressed a lack of continuity in community-related activities. Several organizations that have provided programs for this community have either ceased to exist or have not continued their activities at the same level, leaving the community with a sense that they have no place to turn to for support for themselves or their friends.

Participants in the DC focus group for gay/bisexual Hispanic/Latino men identified a need for prevention information in Spanish, as well as more outreach activity in Spanish-speaking neighborhoods, and the establishment of networks and opportunities to socialize beyond bars and similar establishments. (3)

One finding of the Latin American Men Study is that there appears to be enough similarities among groups of different national origin to justify a common HIV-prevention strategy for

Hispanic/Latino MSM. Issues such as language dominance, immigration status, and unemployment are likely to be more relevant to the design of a prevention program than the national ancestries of various Latino MSM. (2)

New York City's Empowerment program for Hispanic/Latino MSM provides eight sessions that focus on critical experiences likely to have occurred to this population, eliciting personal associations, promoting critical analysis about the consequences that such experiences had in the life of the participants, and discussing their feelings of disempowerment. This is followed by a period of collective problem solving to find alternative, more empowering ways to deal with everyday demands, including safer sex behavior. The process is facilitated, but not prescribed, by an activist or educator. (1)

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Young Gay and Bisexual Men

Since there are multiple factors that contribute to HIV risk-taking among young gay men, multi-level prevention programs are necessary - programs that impact variables at individual, interpersonal and social system levels. New young men will come out each year who have not been exposed to prevention campaigns of previous years, thus HIV prevention for young gay men must be ongoing and dynamic. (1)

Engaging, creative programs are needed that address HIV prevention within the contexts of young gay men's lives, incorporating issues of self-esteem, coming out, substance use and interpersonal and social needs. Community-level and peer outreach programs are especially promising, and services for young gay men of color are particularly needed. Since previous sexual history is a strong predictor of current risk-taking behavior, intervention at an early point in a young man's sexual initiation will be maximally effective. (2)

The involvement of community and opinion leaders in prevention efforts will be critical to overcome cultural barriers to prevention, including homophobia, (6) which may discourage young gay men from accessing prevention services. (1) For example, there remains a tremendous stigma to acknowledging gay and bisexual activity in African-American and Hispanic communities. (2)

A study done in California found that, "to be effective, HIV prevention programs must respect the complex, multi-determined nature of sex for young gay men and understand their personal meanings of sex." Seventy two percent of the participants in the study felt they engaged in sex with other men because of the physical pleasures of sex, but the interpersonal roles of sex were also important. They used sex as a way to express affection (46%) and as a relationship-building tool (33%), i.e., to get to know someone, make friends or test the potential for a relationship. Sex also served important psychological functions, i.e., alleviating loneliness (25%), boosting self-esteem/validating one's desirability (23%). (3)

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Heterosexual Men

Focusing HIV prevention efforts on heterosexual male sexual behavior can make a difference in the epidemic among men, their female partners and their offspring. Interventions for heterosexual men can use multiple components, including:

Counseling both men and women. A study of discordant heterosexual couples (where one is HIV-infected and the other is not) found that counseling men and women together increased consistent use of condoms. Of the 124 couples who did use condoms consistently for vaginal and anal intercourse, none of the negative partners became infected, despite a total of about 15,000 episodes of intercourse. (1)

Helping men rethink notions of intimacy. Programs can address different male beliefs, and use consciousness raising to address the notion of gender roles and coercive behaviors in men, as well as help men embrace an idea of intimacy that can work in conjunction with HIV prevention. Skills building to increase sexual impulse control can also help men deal with violence and coercion, as well as help reduce number of partners. (2)

Heterosexual male peer education. In addition to couples counseling, programs should provide counseling for and by men alone. Research has found that men are interested in family planning, but may not want to discuss it only with their wives or partners. Peer educators can teach and model effective preventive behaviors in settings where men may gather, such as gyms, barbershops or sporting events. (3)

Helping men communicate with women. Like many people in relationships, heterosexual men may find it difficult to talk about sex and love with their partners. One study of young African-American men, for example, demonstrated that regarding sex, men often say what they think their partner wants to hear. (4) Programs that help increase communication skills can be effective.

Focus on men who have sex with men and women (MSMW). A survey of MSMW found that 54% of their female partners did not know about their homosexual activity, and 65% of the men had engaged in unprotected sex with their female partners. (5) Helping MSMW with communication and disclosure skills, as well as skills for correct and consistent condom use, can be beneficial.

Condom social marketing. In Zaire, careful consumer research produced "Prudence," a condom designed and priced to be culturally sensitive, attractive and affordable. Total sales of

Prudence increased 443% from 1988 to 1989, and in many regions of Zaire, the word Prudence has become a generic substitute for the word condom. (6)

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Hispanics / Latinos

For HIV prevention to make a difference, Latinos must attempt to break the silence about sexuality in their communities, address homophobia, and address specific cultural aspects that may be detrimental to healthy sexuality, such as not allowing power for women, and encouraging men to prove their masculinity through intercourse. (1)

Few prevention programs addressing Latinos have been evaluated, and effective behavior change models are still being developed. However, promising programs incorporate extensive preliminary work in targeted Latino populations, (2) use Latino peer educators, stress empowerment and self-esteem building, and expand beyond issues of HIV to incorporate broader issues of relationships, family, and culture.

Porque Sí, an AIDS education video developed for and tested by Latinos, was used at an STD clinic in the South Bronx, NY. Some clients at the clinic were offered the video, or video and interactive group session, as well as coupons for free condoms. Latino clients who saw the video and participated in group sessions were almost twice as likely to redeem coupons as clients who did neither. (3)

Hermanos de Luna y Sol, an ongoing intervention for Latino gay/bisexual men in San Francisco, CA, attracts clients by appealing to brotherhood and the family of gay men. The first group session deals with the common history of oppression among Latino gay men, including issues of homophobia, machismo, sexual abuse, racism and separation from family and culture. AIDS and sexuality are then discussed in the second session. (4)

An AIDS prevention program for Latino youth in Boston, MA, used Latino peer leaders to help teens reduce unprotected sex. They held workshops in schools, community organizations, health centers and in teens' homes, and distributed kits with condoms and instructions. The

program did not increase sexual activity for the teens; males were less likely to start sexual activity and females less likely to have multiple partners. (5)

Programs for heterosexual couples should target both partners, and women should receive routine prenatal HIV counseling and voluntary testing. Prevention programs need to address these populations with Latino-only studies. Many studies include multi-ethnic populations, making it hard to identify Latino-specific findings. (2)

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Hispanic/Latina Women

The authors recommend that HIV prevention interventions to increase condom in this population include consciousness raising designed to address gender role beliefs and coercive behaviors in men, promote equal decision-making, and provide skills building to increase men's sexual impulse control and self-efficacy to use condoms. Prevention programs should also encourage Hispanic/Latina women to carry condoms more, since carrying condoms is a strong predictor of condom use, and to be more skeptical of new partners. (1)

Participants in a DC focus group with Hispanic/Latina women, held in August 1998, felt cultural characteristics in the Hispanic/Latino community may be barriers to safe sex practices and the dissemination of prevention information. They said machismo may cause many in the community to continue to have sex without a condom, and some wives may be naive of the fact that their husbands are having sex with others and see no reason to use condoms in their marital relations. Some of the older women felt that there is much fear of HIV/AIDS based on a Hispanic/Latino cultural focus on the morbid, which inhibits open discussion of the disease and fosters misinformation. (2)

The most significant problem cited by participants in a DC focus group was the lack of information and resources in Spanish. While the young women in the group (with better English skills) felt that there was a good deal of prevention information available and that people just were not paying attention, the older participants said that the information may be available but it does

not reach everyone because it is not in Spanish. The need for more prevention services and information in Spanish was voiced several times by group members.

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Homeless

"Sex, Games and Videotapes" is a program for homeless mentally ill men in a New York City, NY shelter that is built around activities central to shelter life: competitive games, storytelling, and watching videos. For many of these men sex is conducted in public spaces, revolves around drug use, and must be conducted quickly. One component of the program is a competition to see which man can put a condom on a banana fastest (without tearing the condom)-this teaches important skills for using a condom quickly. The program allows for sex issues to be brought up in a non-judgmental way. This program reduced sexual risk behavior threefold. (1)

In San Francisco, CA, HIV tests were offered to homeless people at shelters, food lines and parks, and HIV+ people were given referrals to early intervention. (2) Another testing program was linked to specialized case management to help respond to multiple clients' needs such as access to primary care, substance abuse treatment, and mental health services. Case managers were able to maintain contact and build relationships with drug using clients, many of whom were HIV+ or mentally ill. (3)

A pilot program for homeless women in New York City, NY, some of whom engage in survival sex and are victims of rape and abuse, provides methods of protection women can use in the most difficult circumstances. The women are given Advantage 24 (a time-release Nonoxynol-9 gel) and female condoms, and then learn to use these on a regular basis. As methods they can control, these provide a base for empowerment. (4)

The Teen Peer Outreach-Street Work Project in San Diego, CA, trained teen peer educators to provide HIV prevention education and case management to homeless youth. Food, clothes and shelter information were provided, as well as HIV educational messages. The project found a need for, and subsequently worked to develop, educational materials for homeless youth with low literacy levels. (5)

A successful program for homeless and drug addicted Latina women in Los Angeles, CA, found little difference between women who attended a traditional AIDS education program, and a longer, culturally sensitive program that emphasized problem solving, risk reduction and self-esteem. Shorter, generalized programs may be adequate for addressing more basic needs of impoverished populations. (6)

Nontraditional programs are needed that engage homeless populations at every place they access basic services, such as soup kitchens, shelters, hotels, and clinics. Staff who work in these settings should be trained in HIV prevention education. (6)

Group interventions that have worked in certain settings need to be disseminated and replicated in various institutions. Prevention services must have realistic expectations for change, and must give homeless people concrete goals that they can accomplish. It is difficult to conduct HIV prevention without tackling the bigger issue of homelessness. (6)

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Incarcerated

At the only prison facility in the state of Rhode Island, a comprehensive program addresses needs of prisoners while incarcerated and follow-up after their release. The program involves HIV education in prison, HIV testing and counseling, medical care for HIV-infected prisoners, and pre-release counseling and post-release monitoring of HIV-infected individuals. Pre-release counseling included medical care, drug abuse, housing, and financial support needs of prisoners. One year after release, 73% of HIV-infected inmates were receiving follow-up medical care. (1)

A community follow-up intervention targeted incarcerated youth aged 13-19 in the District of Columbia. The program reinforced risk-reduction behaviors by providing adult mentoring, peer support, and access to health care services. (2)

Weekly HIV/AIDS education and support groups were set up for female inmates at a facility in New York City, NY. The groups were facilitated by a community-based organization, and focused on communicating with family members and close contacts about risk behaviors, locating medical care, and other HIV-related information. (2)

Men at a large state prison in California can take part in a comprehensive intervention program that includes: HIV-positive inmate peer education, pre-HIV test counseling, health promotion for HIV-positive inmates, pre-release educational booster session, discharge planning and community follow-up. The success of these programs involves ongoing support and input from inmates, guards and correctional officers, prison counselors, educators, administrators and the prison medical team. (3)

Ongoing training and education for prison staff (guards, nurses, doctors) is key for ensuring that programs are consistent and sustainable within institutions. (4)

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Injection Drug Users and Substance Abusers

The goals of HIV prevention and substance treatment are often conflicting. Many treatment programs focus on stopping substance abuse altogether, and 12 Step programs often advocate sexual abstinence while in recovery. On the other hand, many prevention programs focus on safer sex and harm reduction, acknowledging that relapse could occur. These conflicting cultures may make it difficult to integrate HIV prevention interventions into substance abuse programs. (1)

New Leaf (formerly 18th Street Services) in San Francisco, CA, provides substance abuse treatment for gay/bisexual men, and offers a safer sex intervention. Although evaluation of the intervention showed little difference between men who participated in the safer sex program, and men who only went through treatment, both groups showed significant reductions in sexual risk. (2) Getting and retaining substance abusers in treatment is an effective preventive method; adding a safer sex program may also help.

Some prevention efforts teach safer sex behaviors regardless of drug use. In "Sex, Games, and Videotapes," a program for homeless mentally ill men in New York City, NY, the men suggested taping condoms to their crack pipes as a reminder for sexual encounters that are often quick and public. They also compete to see which man can put a condom on a banana fastest (without tearing the condom), which teaches important skills for using a condom quickly. The program allows for sex issues to be brought up in a non-judgmental way, and reduced sexual risk behavior threefold. (3)

Many substance abusers receive treatment only after they have been arrested and are offered treatment as an alternative to jail or prison, or while they are incarcerated. The Delaware correctional system has instituted a therapeutic community (TC) treatment program in prison and a transitional TC outside the prison for parolees. The drug-free residential program includes rehabilitation, peer education group counseling and social services. Participants in the TC program had lower rates of drug relapse and re-arrest than non-participants, and reported reduced HIV risk behaviors. (4)

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Seniors

Cultural and generational issues need to be considered in crafting HIV prevention efforts. Older persons may not be comfortable disclosing their sexual behaviors or drug use to others. This can make it difficult to find older adults who attend support groups. (1)

Few prevention programs exist that target adults over 50. Most programs for older adults offer support for HIV+ persons, or target clinicians and caregivers of older adults. Promising prevention programs incorporate generational concerns, target high-risk groups such as older gay men and older women (especially recent widows), and involve older adults in their design and as peer educators. (2)

Senior HIV Intervention Project (SHIP) in Florida's Dade, Broward and Palm Beach Counties, trains older peer educators to present educational and safer sex seminars at retirement communities. Trained AIDS educators meet with health care professionals and aging services workers to help them understand the risk posed to seniors by HIV. (3)

In six regional senior centers in Chicago, IL, a program used peer-led "study circles" to increase HIV awareness and knowledge. Participants viewed a video, "The Forgotten Tenth," and did their own research as to how HIV affects their lives physically, politically and economically. They then shared their knowledge at the next meetings. After the program many participants became AIDS educators. (4)

An HIV education program for older adults was conducted at meal sites in Florida. Based on the Health Belief Model, the program included facts and statistics on older persons and HIV, condom use instruction, HIV testing information, and case studies of older persons with AIDS. After the session, participants reported a significant increase in knowledge about AIDS and perceived susceptibility to HIV. (5)

Clinicians and service providers for older adults, including care takers and nursing home staff, need to be educated on HIV risk behaviors and symptoms of HIV infection among older adults. Clinicians need to conduct thorough sex and drug use risk assessments with their patients over 50, and challenge any assumptions that older people do not engage in these activities or will not discuss them. (2)

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Transgendered

The San Francisco Transgendered Advisory Committee made two major recommendations to improve prevention services for this community (1), including:

- Hiring and training MTF and FTM transgendered individuals as support group facilitators, client advocates, substance abuse counselors, media campaign coordinators, case managers and outreach workers could facilitate access to services for the transgendered community. Employing transgendered staff would also provide jobs to a community that has suffered severe employment discrimination.
- Transgendered sensitivity training for service providers A training unit responsible for developing and implementing in-service trainings should be formed to ensure that systematic training of all service providers takes place on an ongoing basis.

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Women

Recruiting women as community leaders was the basis for an effective HIV prevention program among low-income urban women living in housing developments. Women opinion leaders were trained to lead risk reduction workshops, provide HIV educational materials and condoms, and conduct HIV education through community events. The women effectively mobilized their residential community through tailored prevention messages and activities. (1)

Because women at risk are not always visible as a specific population or community, programs must strive to be where women are. A program provided HIV prevention services for women visiting their incarcerated male partners at San Quentin State Prison. The program, based at the visitor's center, trains women visitors as HIV educators, and the educators provide group and individual peer education. The program is low cost and has been well accepted by visitors and by the prison. (2)

Interventions that promote HIV counseling and testing for both members of a couple should be considered. The California Partner Study provided couple counseling in combination with social support to serodiscordant heterosexual couples (where one partner is HIV positive and the other HIV negative). As a result, condom use increased and no new HIV infections were reported among the couples. (2)

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Pregnant Women (Pediatric)

The District of Columbia's Comprehensive HIV Intervention and Prevention Services (CHIPS) for Families project, of the Office of Maternal and Child Health, developed a "Policy Initiative to Reduce Perinatal Transmission of HIV" that encapsulates the recommendations of the federal Health Resources and Services Administration. In 1996, the agency developed a counseling and testing protocol for pregnant women which has been distributed to health care workers.

The document states: "All health care providers that provide care to pregnant women and women of childbearing age should provide routine HIV counseling and offer voluntary testing on-site or by referral… provide to all pregnant women with HIV infection clear information on the risks and benefits of treatment for herself and her infant… (and) make available medical treatments intended to reduce perinatal HIV transmission in accordance with current Public Health Service (PHS) recommendation either on-site or by referral."

Perinatal transmission cannot be prevented if a woman is unaware that she is HIV+. In the U.S. many women first find out they are HIV+ during prenatal screening, or once their child is born and tests positive for HIV. Access to voluntary HIV testing and counseling using trained peer counselors must be made available for all women to help them make informed choices. (1)

Treating HIV+ pregnant women with AZT during pregnancy and delivery, and treating the infant with AZT after birth, has been shown to cut rates of perinatal transmission by two-thirds, from 25.5% to 8.3%. (4) However, some women in the may choose not to use AZT, may have problems adhering to the regimen, or may not be able to afford or access the drugs. (2)

At the Bay Area Perinatal AIDS Center (BAPAC) at San Francisco General Hospital, in San Francisco, CA, HIV+ mothers receive antiretroviral therapy and further treatment/control of maternal HIV disease, and babies are given AZT for six weeks following birth. None of the 71 HIV+ mothers transmitted HIV to their infants and none of the mothers breastfed. (3)

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Effectiveness of HIV Prevention Interventions

Effective HIV prevention interventions reduce or eliminate the transmission of HIV by averting or reducing HIV-related risk behaviors. The biggest barrier to knowing which interventions are most effective at preventing the spread of HIV is that few interventions have been evaluated formally. And of those that have, many of the evaluations have not been rigorous enough to provide highly reliable information.

This section, and the CDC's "Compendium of HIV Prevention Interventions with Evidence of Effectiveness" (**Page 4.37)**, provide information on the effectiveness of different prevention interventions. A table on **Page 4.66** lists the interventions that have been found to be effective and the studies that have been done to evaluate their effectiveness.

Effectiveness of Individual Level Interventions: Counseling

Although HIV antibody testing should be delivered in the context of counseling (21), counseling is not always delivered in the context of testing. Sometimes stand-alone counseling interventions have been used as comparative conditions to counseling and testing (22). Several studies have evaluated one-on-one or small group, risk-reduction counseling interventions completely unlinked to HIV antibody testing. Many of these studies were randomized, controlled trials examining behavioral outcomes (1-20). The preponderance of evidence from these trials suggests that behavioral interventions decreased risky drug- or sex-related activities (1-3,5,6,8,9,11-13, 15-19).

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Effectiveness of Counseling and Testing

A review of the relevant research prior to 1991 (Higgins et al, 1991) found that counseling and testing tended to reduce HIV-related risk behaviors in specific populations - especially among heterosexual couples discordant in HIV serostatus and among gay men testing HIV positive. Overall, however, little evidence supports the notion that HIV antibody counseling and testing for HIV seronegative people lead to favorable behavior changes.

"For persons testing HIV negative, behavioral science theory and research suggest the need to strengthen the duration and intensity of counseling and other preventive services . . ." (Holtgrave, 1993).

It has been suggested, therefore, that counseling and testing efforts should not necessarily be the center of HIV prevention efforts and that the effect is stronger when counseling, testing, referral, and partner notification (CTRPN) is embedded in a long-term prevention program (Coates & Stryker, 1991).

In a review of literature on prevention programs, Choi and Coates (1994) said: “HIV counseling and testing have a place in HIV risk reduction, but are not sufficient for HIV reduction. HIV counseling and testing do have impact on certain behaviors in certain populations. For example, HIV counseling and testing is associated with lowering sexual risk behavior among homosexual men and injection drug use among IDUs. HIV counseling and testing with couples is associated with reductions in transmission among serodiscordant couples. However, HIV counseling and testing has not had an impact on pregnancy decisions among seropositive women. Only modest effects were demonstrated with STD clinic patrons."

CTRPN programs, which include counseling designed to change HIV-related risk behaviors, have probably undergone more evaluation than any other HIV prevention program. Higgins and colleagues (1) reviewed the literature on behavioral consequences of HIV antibody counseling and testing. They found that counseling and testing tended to reduce HIV-related risk behaviors in specific populations-especially among heterosexual couples discordant in HIV serostatus and (though slightly less obvious from the data) gay men testing HIV seropositive. For instance, researchers in four studies of discordant, heterosexual couples reported substantial increases in their consistent use of condoms after HIV antibody counseling and testing (1).

Research on persons learning their HIV seronegativity in the context of counseling and testing has yielded mixed results (1-8). Several studies found either little or no effect on high-risk behaviors for those aware of their own serostatus and in counseling (1,2,4,5), or a higher risk for those learning their seronegativity than those unaware or untested (1,3,7). One study found some risk reductions (6). Overall, little evidence supports the notion that HIV antibody counseling and testing for HIV seronegative persons (as implemented in these studies) lead to favorable behavior changes (8). The preponderance of evidence, however, shows the experience is not harmful for them either. For persons testing HIV seronegative, behavioral science theory and research suggest the need to strengthen the duration and intensity of counseling and other preventive services tailored to client-specific needs and the quality and suitability of delivering both counseling and testing services (9,10).

For the partners of HIV-infected persons, one basic benefit comes from being informed that they are at risk. This will be particularly helpful information for those who do not even suspect that they might have been exposed. Once informed, the partner can decide to access available HIV prevention counseling and testing services. If not infected with HIV, partners can be assisted in changing their risk behavior, thus reducing the likelihood of acquiring the virus. Or, if already HIV-infected, the partner’ s prognosis can be improved through earlier diagnosis and treatment.

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Effectiveness of Group-level Interventions

Group-level interventions have been effective in promoting safer sex behavior among gay and bisexual men (Choi & Coates, 1994). This approach has been shown to have an impact on motivation, attitudes, and behavior. It should be noted, however, that research has primarily examined the effect of group interventions among predominately white, college educated, and self-identified older gay men. Whether this approach would have a similar influence among members of other ethnic groups, non-gay-identified men who have sex with men (MSM), or younger MSM remains to be demonstrated.

For injection drug users in treatment, participants in an enhanced six session intervention on HIV education showed better ability to make decisions about risky behavior immediately following the intervention than participants in single session information sessions. However, follow up data did not reflect significant differences in behavior between the two groups (McCuster et al., 1992.)

A review of research sponsored by the National Institute of Mental Health found that participants in a multiple session intervention with the mentally ill, while showing success in increased knowledge and intention to use condoms immediately following the intervention, were not able to sustain those changes.

Multiple sessions have a greater possibility of effecting consistent behavior changes than one-time interventions. A study of African-American gay and bisexual men in San Francisco demonstrated that men who participated in multiple session groups had higher levels of behavior change, and maintained behavior change over time more successfully than those who attended single session groups (Peterson, 1993).

Kirby and colleagues (1994) summarized studies evaluating specific school-based programs. Three categories of programs were assessed: programs promoting abstinence, programs including both abstinence and contraception, and education plus reproductive health services. Regarding the first category, the authors conclude that, "There is not sufficient evidence to determine if school-based programs that focus only upon abstinence delay the onset of intercourse or affect other sexual contraceptive behaviors" (p. 352). In reviewing the data on the second category of programs, the authors point out that "these data strongly support the conclusion that sexuality and AIDS education curriculums [sic] that include discussions of contraception in combination with other topics-such as resistance skills-do not hasten the onset of intercourse. They also demonstrate that some, but not all, programs can delay the initiation of sex" (p. 353). Furthermore, some, but not all, of the programs evaluated increased contraceptive use among the students. In summarizing the data concerning school-based programs providing reproductive health services either on campus or nearby, Kirby and colleagues found that these programs neither hasten the onset of intercourse nor increase the frequency. Although the effect on contraceptive use was not clear due to inconsistent findings, the data were "consistent with the hypothesis that the presence of a strong educational component is more critical than provision of reproductive health services" (p. 356).

Effectiveness of Hotlines

Hotlines may be especially utilized by persons who are geographically isolated or who are too self-conscious to seek information in person. Typically, HIV/AIDS hotlines provide informational services rather than skilled crisis services. While the brief contacts that usually characterize hotlines are probably not enough to promote behavior change, they can be effective as sources of referral to testing and other HIV services. In addition, by providing access to valid HIV/AIDS information, hotlines may be useful for reducing anxiety about AIDS among the general public.(11)

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Effectiveness of Outreach

Street Outreach has been quite effective in reaching at-risk individuals who may otherwise be unlikely to access HIV prevention services and education, and can provide repeated exposures to HIV information. The interventions are most productive when the outreach workers are peer educators who have similar backgrounds as the target population. Evidence for the success of outreach comes mainly from the results of the National AIDS Demonstration Research Program (NADR) and suggests that this strategy effectively reduces unsafe needle

practices among IDUs and, to a lesser degree, increases consistent condom use (Stephens et al., 1993).

Outreach promoting safer sex among gay men has been found to bring about short-term behavior change (e.g., in frequency of high-risk sexual behaviors); long-term impact has yet to be established (Choi & Coates, 1994). Street outreach programs have also targeted commercial sex workers with some success. Evaluations of these programs have been conducted in developing countries and have found that consistent condom use with clients increased among sex workers in Nigeria, Zimbabwe, and Ghana (cf. Choi & Coates, 1994). Street outreach may have the greatest impact on sex- and drug-related behavior when delivered by trained peers and when accompanied by the provision of appropriate preventive material, such as condoms and bleaching kits.

Through a variety of information, education, and counseling sessions, HIV prevention programs have attempted to get IDUs to stop using and injecting drugs, stop using unclean needles and syringes, and stop engaging in high-risk sexual behaviors (1-9, 13). Whether offered early or late in the treatment process or as standard (short, one-time) or enhanced (longer, multiple) versions, these sessions generally reduced IDUs' risky drug behaviors (especially those needle-related). Their impact on modifying sex-related risk behaviors such as casual partners or exchanging sex for drugs or money was less obvious and requires further study (2-13).

The NADR Project assessed longitudinal data from 28 sites delivering street outreach services to a total of 13,475 IDUs and 1,637 sex partners of IDUs (10). Study participants were randomly assigned to standard or enhanced AIDS education and counseling sessions. At the 6-month follow-up, a clinically meaningful and statistically significant reduction was found for the following high-risk behaviors of IDUs for both intervention assignments: frequency of injecting drugs, use of non-injected drugs, use of borrowed injection equipment, and number of sex partners. Twenty-eight percent fewer of the total IDU sample reported injecting daily at follow-up than at baseline (42 percent versus 70 percent). Twenty-four percent fewer reported borrowing needles at follow-up than at baseline (24 percent versus 48 percent) and 8 percent fewer reported having two or more sex partners during the preceding 6 months (36 percent versus 44 percent).

Furthermore, favorable behavior changes were found for use of new needles, bleach to clean injection equipment between uses, and condoms. Among the 13,475 IDUs, 21 percent more reported always using new needles at follow-up than at baseline (40 percent versus 19 percent), and 9 percent more reported always using condoms (19 percent versus 10 percent). Several factors contributed to the favorable impact of street outreach services, including using outreach workers from the community (often ex-addicts), providing bleach and condoms and demonstrating their correct use, and offering training in sexual negotiation and refusal skills (14).

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Effectiveness of Needle Exchange

The number of studies showing beneficial effects on behaviors such as needle sharing greatly outnumber those showing no effects. Needle exchange programs (NEPs) have been implemented successfully in a number of communities that have sanctioned this strategy. Available information indicates that NEPs effectively reduce the frequency of sharing needles and syringes and may improve needle hygiene, such as using bleach to clean needles (Lurie et al, 1993). Studies show reduction in risk behavior as high as 80 percent in injecting drug users, with estimates of a 30 percent or greater reduction of HIV. The impact on sexual behavior is less clear, although it appears that there is no increase in risky sexual behavior associated with NEPs. The cost of such programs is relatively low.

Effectiveness of Prevention Case Management

As summarized in a recent report (Holtgrave et al, 1994), "Several studies evaluated one-on-one . . . risk-reduction counseling interventions unlinked to HIV antibody testing. The preponderance of evidence from these trials suggests that behavioral interventions decreased risky drug- or sex-related activities." The effect of individual-level counseling may be limited, however, by the degree to which the intervention is culturally and linguistically appropriate, by the intensity and duration of the intervention, and by the number of contacts. According to Holtgrave and colleagues (1994), "long-term behavior change with one-time HIV prevention interventions should not be expected." Thus, individual-level counseling may be most effective when delivered by trained peers over multiple occasions.

There are many reasons to believe that Prevention Case Management can act as an effective strategy in prevention HIV infection. PCM is able to assist an individual to address all of the potential risk factors that can lead to unsafe behavior. In addition, personal efficacy – which can be built through PCM – is one of the strongest predictors of low sexual risk-taking.

Effectiveness of Partner Counseling and Referral Services

The role of PCRS, earlier diagnosis, and prevention and treatment services might have prevention benefits at the community level in reducing future rates of HIV transmission. Evidence is accumulating that antiretroviral therapy reduces the amount of HIV in genital secretions and fluids and thus might reduce the infectivity of HIV (Gupta P, *et al.*, 1997; Vernazza PL, *et al.*, 1997; Vernazza PL, *et al*., 1997; Musicco M, *et al*., 1994).

However, concern may be well justified that some might misinterpret antiretroviral therapy as a cure for HIV and thus be less concerned about adopting safe behaviors or exposing others (Kalichman SC, *et al*., 1998; Kelly JA, *et al.*, 1998; Remien RH, *et al*., 1998; Remien RH, *et al*., 1998). Efforts to link HIV-infected persons to treatment must also continue to emphasize safe behavior during the course of treatment. Effective PCRS also can improve disease surveillance, identify social sexual networks at high risk that can then be targeted for prevention (Fenton and Peterman, 1997), and potentially assist a comprehensive program in lowering the transmission rate of HIV. In addition, PCRS can benefit service providers in the community by increasing their access to individuals in need of their services, especially people who would not come to them on their own.

Effectiveness of Health Communications/ Public Information

Publicly funded information dissemination programs have led to an overall increase in basic HIV knowledge in the general population (1-6). Most striking is data from the National Health Interview Survey (NHIS), a probability sample of the United States population, which showed that basic knowledge of modes of HIV transmission increased greatly over the last several years (5,6). For example, among 42,726 adults queried for the 1991 NHIS, 95% responded "true" to the statement, "Any person with the AIDS virus can pass it on to someone else through sexual intercourse;" and 94% responded "true" to "A pregnant woman who has the AIDS virus can give it to her baby" (5).

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Effectiveness of Social Marketing

Social marketing has been used more extensively outside the United States than domestically to promote HIV prevention. Evaluations of media campaigns in Switzerland and France demonstrate that "media programs, effectively designed and executed, can change behavior significantly" (Coates & Stryker, 1994). In California, the use of fotonovelas and radionovelas to disseminate AIDS information to Spanish-speaking migrant farm workers has been successful in changing knowledge, attitudes, and use of condoms among prostitutes (Conner, 1992). The Centers for Disease Control and Prevention's AIDS Community Demonstration Projects developed small media pieces distributed via peer volunteer networks to injecting drug users and their female sex partners, non-gay-identified men who have sex with men, female sex workers, and high-risk youth (youth not at home and not at school). Findings show that the intervention was successful in accessing members of these hard-to-reach populations. Moreover, the data suggest that compared to those not exposed to the intervention, those who were exposed tended to use bleach more consistently for cleaning injection equipment and condoms more consistently during sexual intercourse (Jamner, Corby, & Wolitski, in press).

A key element to social marketing is the two-way flow of communication between the producer of educational materials or programs and the intended consumer. Formative evaluation, a process by which products or messages are developed in cooperation with members of the target population and pre-tested before being distributed on a wide scale, is an essential component of social marketing. This approach ensures that the intervention will be culturally appropriate for the target population.

Several programs described under street outreach fit into the definition of a community intervention due to the involvement of community members in development and delivery of the intervention (i.e., peer educators or indigenous outreach workers). Thus, the National AIDS Demonstration Research Project (NADR) represented a community-focused

intervention that featured street outreach as a primary strategy for reaching the target community. Similarly, programs that have employed members of the gay population to act as volunteer educators to members of their social group also represent community interventions relying mostly on outreach. As previously discussed, these programs have been successful in bringing about behavior change in the direction of HIV risk reduction.

Effectiveness of Other Interventions

Community-level interventions. Kelly and coworkers (1,2) pointed to community- level interventions as promising for changing HIV-related risk behaviors. Community-level interventions are those that (a) target the community (often defined by sex, geography, risky behaviors, race-ethnicity, or sexual orientation) rather than a specific individual; (b) involve community members in the actual design and delivery of the intervention; and (c) aim to change community norms about high-risk behaviors (as well as modify individual behaviors).

Kelly and colleagues recruited opinion leaders from communities of gay men, trained them in HIV prevention messages and message delivery, and asked them to take these messages back to their communities. Carefully executed, controlled studies showed that this intervention changed community norms and self-reported, risky sexual behaviors (1-4).

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Community Mobilization: Although few attempts have been made to systematically evaluate community mobilization as an approach to HIV/AIDS prevention, it is clear that it can play a critical role in facilitating HIV prevention programs. (1) Many of the intervention strategies cited above depend upon community support for implementation. Specifically, community outreach, needle exchange, and school-based HIV education all require cooperation from community members and institutions in order to be carried out effectively. Thus, although funds are not allocated to support community mobilization, this strategy could be portrayed as essential to the success of virtually all HIV/AIDS prevention programs.

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1. Plan for the Prevention of HIV in Orange County CA, 1996-99, by Nancy H. Corby, Ph.D., and Margaret Schneider Jamner, Ph.D., from the Center for Behavioral Research and Services, California State University, Long Beach.

Venue-based outreach: There is little information on the impact of venue-based outreach interventions, but such activities should increase HIV knowledge, clear up misinformation, and contribute to the development of a social norm favoring risk reduction behaviors. (1)

References

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Compendium of HIV Prevention Interventions with Evidence of Effectiveness

Developed by the Centers for Disease Control and Prevention, HIV/AIDS Prevention Research Synthesis Project, March 1999.

Introduction

The Centers for Disease Control and Prevention (CDC) developed this *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* to respond to prevention service providers, planners, and others who request science-based interventions that work. All interventions selected for this *Compendium* came from behavioral or social studies that had both intervention and control/comparison groups and positive results for behavioral or health outcomes. We required designs with control/comparison groups so that successful results could be attributed to the interventions. This document provides *Summaries of* each intervention that met all criteria. These are referred to as effective interventions. To meet the ongoing need for current information about what works in HIV prevention, this *Compendium* will be updated approximately annually.

The *Compendium* provides state-of-the-science information about interventions with evidence of reducing sex- and/or drug-related risks, and the rate of HIV/STD infections. These interventions have been effective with a variety of populations, e.g., clinic patients, heterosexual men and women, high-risk youth, incarcerated populations, injection drug users, and men who have sex with men. They have been delivered to individuals, groups, and communities in settings such as storefronts, gay bars, health centers, housing communities, and schools.

Once an intervention is adopted, its actual impact will depend on how it is implemented. The important thing is to achieve a balance between adapting the intervention to suit local needs and maintaining the core elements and key characteristics that made the original intervention successful. Also, the agency that implements the intervention will require organizational support, adequate staffing, and sufficient resources for implementation.

Summaries are grouped by target populations: Injecting Drug Users, Heterosexual Adults, Men Who Have Sex with Men, and Youth. A shaded box at the beginning of each summary indicates the populations that participated in the interventions.

The summaries use a standard format, with the same elements used to describe each intervention. If an element is missing from a Summary, it is because the source citation does not contain that information. The following elements comprise the format:

Title, authors, reference - bibliographic information for the source report (usually a journal publication, but may be "in press" or "submitted for publication")

Intervention goal(s) - selected behavioral/health aims of the intervention (most often other aims exist but are outside the scope of the *Summary)*

Intervention setting - the type of place in which the intervention was conducted

Population - includes the following features: sample size - the number of people who participated (usually the total number in the intervention and control conditions of the study at baseline)

Demographics - selected characteristics of the participants (e.g., gender, race/ethnicity, age, education, income)

Comparison condition - describes briefly what. was provided to participants who did not receive the intervention during the study (e.g., a non-HIV intervention, usual HIV services such as HIV education and HIV counseling and testing)

Intervention description - includes the following features:

theory/model - the basis for the design of the intervention, which explains the behavior change

duration - the length and number of intervention sessions

Location - where the intervention was carried out

Characteristics of facilitators/leaders e.g., gender, race/ethnicity, age

Content- e.g., topics, information, skills pertaining to risk reduction

Method(s) - how the intervention was delivered or conducted

Handout(s) - materials given to participants

Incentives - cash/items used to encourage or support participation

Findings- selected behavioral or health outcomes (usually at three or six months after intervention)

Contact person - the research scientist (or designee) who conducted the intervention and/or its evaluation

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Injecting Drug Users, Heterosexual Adults, MSM and Youth (Men and Women)

Community-level HIV Intervention in Five Cities: Final Outcome Data from the CDC AIDS Community Demonstration Projects

AIDS Community Demonstration Projects Research Group (1999) American Journal of Public Health, 89 (3), 336-345

Intervention Goal(s): To determine the effects of a community-level intervention to increase condom use with main and non-main partners and/or to increase disinfection of injection equipment.

Intervention Setting: Street settings, public sex environments, and other community venues.

Population: Interviews were conducted with 15,205 individuals who were injection drug users, female sex partners of injection drug users, commercial sex workers, non-gay-identified men who have sex with men, high-risk youth, and/or residents in census tracts with high rates of sexually transmitted disease. Of the interviewees, 46% were men and 54% were women; 54% were African American, 19% were Hispanic, 22% were white, and 5% were of other racial/ethnic groups; and 35% were under 30 years of age.

Comparison Condition: Usual HIV prevention activities and services available in the community.

Description of Intervention: AIDS Community Demonstration Project

This community-level intervention was based on the Transtheoretical. Model of Behavior Change, which recognizes that change occurs in stages. The intervention aimed to modify attitudes and beliefs about prevention methods among the community members by providing models of successful risk-reduction strategies adopted by members of the target population. The intervention took place over 3 years in Dallas, Denver, Long Beach, New York City, and Seattle. Peer volunteers from each target community were trained to carry out the intervention, drawing attention to and reinforcing identification with and acceptance of the intervention messages.

The intervention featured role model stories developed from the real-life experiences of local community members. These stories depicted members of the target population moving from earlier to later stages of change. Stories were developed and selected so that the majority matched the predominant stages of change and beliefs about condoms and bleach observed in the population.

The role model stories were featured in flyers distributed with condoms and bleach kits by the peer volunteers.

Behavioral/Health Findings: Individuals in the intervention communities demonstrated significantly greater achievement of consistent condom use and maintenance of consistent condom use with non-main partners than individuals in the comparison communities.

Contact: Behavioral Intervention Research Branch Division of HIV & AIDS Prevention Centers for Disease Control and Prevention Atlanta, GA 30333 Phone: 404-639-1900 Fax: 404-639-1950 E-mail: rywl@cdc.gov

Injecting Drug Users (Men and Women)

AIDS and the Transition to Illicit Drug Injection: Results of a Randomized Trial Prevention Program

Des Jarlais, D.C., Casriel, C., Friedman, S.R., Rosenblum, A. (1992). British Journal of Addiction 8 7 (3), 493-498

Intervention Goal(s): To determine the effects of a small group intervention to prevent the transition from sniffing heroin to injecting heroin.

Intervention Setting: Community storefront.

Population: Of the 83 drug users (heroin sniffers) who participated in the study, 69% were men and 31% were women; 23% were African American, 26% were Hispanic, and 51% were white. The average age of the participants was 28 years.

Comparison Condition: AIDS information and HIV antibody pretest counseling (HIV test optional).

Description of Intervention: AIDS/Drug Injection Prevention

This prevention program was based on social learning principles. The intervention was delivered in four 1 - to I 1/2-hour sessions over a 2-week time period. The intervention was led by 2 trainers who encouraged a therapeutic atmosphere in which participants felt free to discuss personal problem situations and seek help from the trainers and from their peers. Reduction in non-injected use of illicit drugs was an additional goal of the program. Trainers were clear not to take a condemning/punitive attitude, The emphasis was on recognizing and admitting problems with illicit drug use and then seeking treatment to reduce/eliminate the illicit drug use.

The four sessions covered understanding AIDS, risks of drug use and drug injection, sexual behavior and AIDS, and seeking entry into drug abuse treatment programs. The trainers used presentations, group discussion, and role-play of critical situations like refusing an offer of injection or seeking entry into a treatment program when one's non-injection drug use becomes too heavy.

Behavioral/Health Findings: Men and women who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition.

Contact: Don C. Des Jarlais, Ph.D. Chemical Dependency Institute Beth Israel Medical Center 1st Avenue at 16th Street New York, NY 10003 Phone: 212-387-3803 Fax:212-387-3897 E-mail: dcdesjarla@aol.com

Injecting Drug Users (Women)

15-month Follow-up of Women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission

El-Bassel, N., & Schilling, R.F. (1992). Public Health Reports 107 (5), 500-504

Intervention Goal(s): To determine the effects of a small group intervention to reduce sexual risk behavior and HIV transmission by increasing AIDS knowledge, sexual negotiation skills, and safer sex practices.

Intervention Setting: Methadone maintenance clinics.

Population: Of the 84 female methadone patients who participated in the study, 36% were African American and 64% were Hispanic. More than 90% of the women were between the ages of 21 and 42 and 90% were unemployed.

Comparison Condition: HIV/AIDS information only.

Description of Intervention: Skills Building

The intervention was delivered in five 2-hour sessions with about ten women in each group.

The intervention was led by experienced female drug counselors who had received an additional 20 hours of training.

Sessions 1-2. Information on AIDS transmission and prevention. Trainers used video, other visual presentations, and didactic exercises to enable participants to identify their own high-risk sexual behaviors and barriers to adopting safer sex practices.

Session 3. Condom use. Members discussed their negative associations with condoms, practiced condom skills, and role-played scenarios that involved asking their partners to use condoms.

Sessions 4-5. Assertiveness training, problem solving, and communication skills. Participants practiced and personalized these skills, first by role-playing in scripted scenarios, then by selecting scenarios that reflected their own life.

Incentives included modest payments for attending the sessions.

Behavioral Findings: Women who participated in the intervention significantly increased frequency of condom use with their partners compared with women in the comparison condition.

Contact: Nabila El-Bassel, DSW Columbia University School of Social Work 622 West 113th Street New York, NY 10025 Phone:212-854-5011 ,Fax:212-854-8549 E-mail: ne5@columbia.edu

Injecting Drug Users and Youth (Men)

Outcomes of Intensive AIDS Education for Male Adolescent Drug Users in Jail

Magura, S., Kang, S., Shapiro, J.L. (1994). Journal of Adolescent Health, 15 (6), 457-463

Intervention Goal(s): To determine the effects of a small group intervention to reduce HIV drug- and sex-related risk behaviors.

Intervention Setting: A detention center.

Population: Of the 157 incarcerated, young, male drug users who participated in the study, 65% were African American, 33% were Hispanic, and 2% were white. Median age was 18 years, ranging from 16 to 19 years.

Comparison Condition: The intervention was given to comparison participants at a later time.

Description of Intervention: Intensive AIDS Education in Jail

The intervention was based on a problem solving therapy model. It consisted of four 60- minute sessions focusing on health education issues relevant to male adolescent drug users, with emphasis on HIV/AIDS. The intervention was delivered at the New York City Department of Corrections Adolescent Reception and Detention Center on Rikers Island. Sessions used interactive methods and a small group format with 8 adolescents and one male counselor. Counselors were guided by a written curriculum. Topics included general health knowledge, HIV and AIDS knowledge, factors associated with initiation and continuance of drug abuse, types of sexual behavior and HIV risk, the relationship of drug use and sexual behavior, and strategies to access services and drug abuse treatment in the community. Counselors adapted topics to the needs of the participants. Counselors used techniques based on the problem-solving therapy model:

- Problem orientation - group members share and discuss facts and beliefs about HIV/AIDS
- Problem definition and formulation - members define specific high-risk attitudes and behaviors that must be modified to protect themselves and others against HIV/AIDS
- Generation of alternative solutions - members suggested and compiled possible courses of action for risky behaviors
- Decision-making - members critiqued and evaluated the alternative solutions 0 Solution implementation - participants used role play and rehearsal techniques to practice alternative solutions.

The young men received $5 for each group session they attended.

Behavioral Findings: After release from jail, youth who participated in the intervention were significantly more likely to use condoms during vaginal, oral, and anal sex and had fewer high-risk sex partners than youth in the comparison condition.

Contact: Stephen Magura National Development and Research Institutes, Inc. 2 World Trade Center, l6th Floor New York, NY 10048 Phone: 212-845-4521 Fax:212-845-4698 E-mail: steve.magura@nclri.org

Injecting Drug Users (Men and Women)

AIDS Education for Drug Abusers: Evaluation of Short-term Effectiveness

McCusker, J., Stoddard, A.M., Zapka, J.G., Morrison, C.S., Zorn, M., Lewis, B.F. (1992). American Journal of Public Health, 82 (4), 533-540

Intervention Goal(s): To determine the effects of small group Informational and Enhanced Education interventions to reduce drug- and sex-related HIV risk behaviors.

Intervention Setting: Inpatient drug detoxification and rehabilitation center.

Population: Of the 567 adult drug users who participated in the study, 67% were men and 33% were women; 81% were white; and 70% were high school graduates.

Comparison Condition: Essential HIV/AIDS information, using primarily didactic methods.

Description of Intervention: Informational and Enhanced AIDS Education

The interventions drew primarily from Social Cognitive Theory and Relapse Prevention

Theory, and also included concepts from the Health Belief Model and Theory of Reasoned Action. The Informational Education intervention consisted of two sessions. The Enhanced Education intervention was delivered in six sessions. When the six sessions were completed, participants received a 30-minute individual health education consultation.

The Informational Education intervention provided the essential HIV/AIDS information (prevention, transmission, etc.), using primarily didactic methods including video, lecture, discussion, homework, and demonstration (but not practice) of condom use and cleaning of drug paraphernalia. The Enhanced Education intervention focused on personal susceptibility, situation analysis and skills building. Participants engaged in group discussions and practiced skills they could use to reduce risk in various situations. Additional strategies were homework assignments, tension-release exercises, role-playing, trigger tapes, peer feedback, and needle cleaning and condom skills exercises. Emphasis was placed on experiential learning

techniques for the purpose of enhancing participants' self-efficacy regarding their ability to initiate and maintain AIDS harm-reduction

Behavioral Findings: After exit from the program, participants in both interventions reported significant reductions in drug- and sex-related risk behaviors compared with their baseline level of risk. For two behaviors, drug injection and cocaine use, the Enhanced Education intervention had significantly greater effects that the Informational Education intervention.

Contact: Jane McCusker, MD, Ph.D. Department of Clinical Epidemiology and Community Studies Room 2508 St. Mary's Hospital 3830 Lacombe Avenue Montreal, Quebec, Canada 113T lM5 Phone: 514-345-3511, ext. 5060 Fax:514-734-2652 E-mail: janemc@epid.lan.mcgill.ca

Heterosexual Adults (Men and Women)

Condom Skills Education and Sexually Transmitted Disease Reinfection

Cohen, D., Dent, C., MacKinnon, D. (1991). Journal of Sex Research, 28 (1), 139-144

Intervention Goal(s): To determine the effects of a small group intervention to reduce the incidence of sexually transmitted diseases (STDs).

Intervention Setting: Waiting room of an STD clinic.

Population: Of the 192 adults who participated in the study, 59% were male and 41% were female; 67% were African American, 14% were Hispanic, and 19% were of other racial/ethnic groups. The median age of the participants was 25 years, ranging from 15 to 61 years.

Comparison Condition: Usual services available in the STD clinic.

Description of Intervention: Condom Skills Education

This intervention was based on the premise that familiarity with condoms and skills in using condoms properly are necessary for increasing future condom use. The intervention consisted of a brief condom skills education session led by a health educator who was an African-American woman. The intervention was delivered in a single 30-minute group session to people waiting for appointments in a Los Angeles STD clinic.

The session began with a 10- to 15-minute presentation in which the health educator emphasized 3 important points for effective condom use: condoms should be made of latex, condoms should have a reservoir tip or space left at the end, and condoms should be lubricated with a spermicide. The session -included group discussion of how condoms should be used and a demonstration of how to put on a condom. The health

educator referred to a poster that displayed a variety of condoms with their packaging. The presentation was followed by a 10- to 15 -minute question-and-answer session.

Behavioral/Health Findings: Men and women who participated in the intervention were significantly less likely to return to the STD clinic within the next 12 months with a new STD than those in the comparison condition.

Contact: Deborah A. Cohen, MD, MPH Department of Public Health and Preventive Medicine 1600 Canal Street New Orleans, LA 70112 Phone: 504-680-9450 Fax: 504-680-9453 E-mail: dcohen@lsumc.edu

Heterosexual Adults (Men and Women)

Group Counseling at STD Clinics to Promote Use of Condoms

Cohen, D.A., MacKinnon, D.P., Dent, C., Mason, H., Sullivan, E. (1992). Public Health Reports, 107 (6), 727-730

Intervention Goal(s): To determine the effects of a small group intervention to promote safer sex and condom use.

Intervention Setting: Waiting room of an STD clinic.

Population: Of the 426 adults who participated in the study, 71 % were men and 29% were women; 83% were African American. The average age of the participants was 28 years.

Comparison Condition: Usual services available in the STD clinic.

Description of Intervention: Group Discussion Condom Promotion

This intervention used the social context of small groups to encourage change in norms, expectations, and social skills. The intervention was delivered in a single group session to people waiting for appointments in a Los Angeles STD clinic. A trained female African-American health educator led sessions for groups of 10-25 participants.

The intervention session began with a video, "Let's Do Something Different," depicting condom use as socially acceptable. After the video a health educator facilitated a group discussion on methods of preventing STDs and promoting condom use. This discussion included the reasons why people liked and disliked condoms.

Role-playing gave the clinic patients an opportunity to practice condom negotiation, first with the health educator and then with another patient. Questions relating to medical aspects of STDs were referred to clinic nursing and medical personnel.

All participants were offered 10 free condoms by clinic nurses.

Behavioral/ Health Findings: Men who participated in the intervention had a significantly lower STD reinfection rate than men in the comparison condition. There was no evidence of change for women.

Contact: Deborah A. Cohen, MD, MPH Department of Public Health and Preventive Medicine 1600 Canal Street New Orleans, LA 70112 Phone: 504-680-9450 Fax: 504-680-9453 E-mail: dcohen@lsumc.edu

Heterosexual Adults (Women)

A Randomized Controlled Trial in an HIV Sexual Risk-reduction Intervention for Young African American Women

DiClemente, R.J., & Wingood, G.M. (1995). Journal of the American Medical Association 274 (16), 1271-1276

Intervention Goal(s): To determine the effects of a small group intervention to increase consistent condom use and prevent HIV infection.

Intervention Setting: Community center.

Population: Among the 128 sexually active African-American women from an economically disadvantaged neighborhood who participated in the study, the average age was 23 years, ranging from 18-29 years.

Comparison Condition: The intervention was given to comparison participants at a later time.

Description of Intervention: Social Skills Training

Social Cognitive Theory and theories of gender and power were used as models to guide the development of this social skills intervention. The intervention consisted of five weekly 2-hour group sessions led by trained African-American peer educators in the Bayview-Hunter's Point community of San Francisco, California. Each session had a specific topic and planned activities for modeling and assessing skills.

Session 1. Gender and ethnic pride. The women discussed positive attributes of being an African-American woman.

Session 2. Personal responsibility for sexual decision making. The women watched an HIV prevention video and had discussion.

Session 3. Sexual assertiveness and communication training. Role-playing exercises were used to practice managing risky sexual situations.

Session 4. Condom use. The women concentrated on building skills and changing social norms for proper condom use.

Session 5. Cognitive coping skills. Participants developed skills such as sexual self-

control.

Behavioral/Health Findings: Women who participated in the intervention were significantly more likely than women in the comparison condition to report consistent condom use with their partners, negotiating condom use, and not having sex when a condom was not available.

Contact: Ralph DiClemente, Ph.D. Rollins School of Public Health 1518 Clifton Road Atlanta, GA 30022 Phone:404-727-0237 Fax:404-727-1369

Heterosexual Adults (Women)

Reducing Inner-city Women's AIDS Risk Activities: A Study of Single Pregnant Women

Hobfoll, S.E., Jackson, A.P., Lavin, J., Britton, P.J., Shepherd, J.B. (1994). Health Psychology, 13 (5), 397-403

Intervention Goal(s): To determine the effects of a small group intervention to enhance AIDS knowledge, attitudes, and skills and, as a result, to influence behavior change.

Intervention Setting: Inner-city clinics for low-income women.

Population: Of the 206 single pregnant women who participated in the study, 57% were African American, 40% were white, and 3% were of other racial/ethnic groups. The average age of the participants was 21 years, ranging from 16 to 29 years. About one-third of the participants had not completed high school; 75% had income of less than $10,000 per year. Comparison Conditions: One was no intervention and the other was health promotion.

Description of Intervention: Reducing AIDS Risk Activities

The intervention was based on theories of 'social learning, conservation of resources (including coping strategies and support skills), and communal support. Clinics were in a mid-sized Midwestern city. The intervention consisted of 4 sessions, 11/2- to 2-hours each, for groups of 2 to 8 women. Trained group leaders were female psychologists and health educators whose ethnic backgrounds were similar to those of the participants.

Sessions featured videos using actors from the target population illustrating assertiveness, negotiation skills, planning skills, and specialized skills (e.g., cleaning drug works). Women discussed the videos and role-played risk scenarios. Participants created health plans. Women learned negotiation skills and assertiveness skills. They developed a sense of mastery and positive expectations of success. The sessions also

included an activity in which women imagined an unhealthy behavior and then imagined a healthy behavior. The final session addressed relapse prevention.

Incentives included cash, partial reimbursement for transportation and child care costs, and participation in a lottery for a color television.

Behavioral Findings: Women who participated in the intervention increased their use of condoms with their partners significantly more than women in the comparison condition who received no intervention.

Contact: Stevan E. Hobfoll, Ph.D. Applied Psychology Center Kent State University P.O. Box 5 190 Kent, OH 44242-0001 Phone:330-672-2137 Fax:330-672-3786 E-mail: shobfoll@kent.edu

Heterosexual Adults (Men and Women; African Americans, Hispanics, Whites)

Efficacy of Risk-reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Disease: A Randomized Controlled Trial

Kamb, M..L., Fishbein, M., Douglas, J.M., Rhodes, F., Rogers, J., Bolan, G., Zenilman, J., Hoxworth, T., Malotte, C.K., latesta, M., Kent, C., Lentz, A., Graziano, S., Byers, R.H., Peterman, T.A., for the Project RESPECT Study Group. (1998). Journal of the American Medical Association 280 (13), 1161-1167

Intervention Goal(s): To determine the effects of enhanced and brief interactive counseling interventions to reduce high-risk behavior and to prevent new STDs.

Intervention Setting: Inner-city STD clinics.

Population: Of the 5,758 HIV-seronegative adults who participated in the study, 57% were male and 43% were female; 59% were African American, 19% were Hispanic, 16% were white, and 6% were of other racial/ethnic groups. Median age of the participants was 25 years; 54% were unemployed.

Comparison Condition: Didactic messages typical of current care.

Description of Intervention: Project RESPECT

The Enhanced and Brief Counseling interventions were based on the Theory of Reasoned Action and Social Cognitive Theory. Sessions were interactive and designed to change factors that could facilitate condom use, such as self-efficacy, attitudes, and perceived norms. The study was conducted in Baltimore, Denver, Long Beach, Newark, and San Francisco. Trained HIV counselors delivered the intervention.

The Enhanced Counseling intervention consisted of 4 sessions, a total of 200

minutes, and was completed in 4 weeks.

Session 1. HIV test and goal setting for risk reduction. The aim was to identify a behavior that could be changed before the next session.

Session 2. Lessons learned from first effort and goal setting for next risk-reduction step.

Session 3. HIV test result, lessons learned, and goal setting for next risk-reduction step.

Session 4. Lessons learned and long-term risk-reduction plan.

The Brief Counseling intervention consisted of 2 sessions, a total of 40 minutes, and was completed in 10 days. This intervention, modeled after CDC's recommended HIV counseling in public clinics and HIV test sites, included:

Session 1. Identical to Session 1 above. Session 2. HIV test results and developing a long-term plan for risk-reduction.

Behavioral Findings: Participants in both counseling interventions reported significantly higher condom use compared with participants in the comparison condition. Of the counseling participants, 30% fewer had new STDs compared with participants in the didactic message condition. In the counseling interventions, benefits accrued equally to men and women and STD reduction was higher among adolescents than older participants.

Contact: Joanne W. Jackson Centers for Disease Control and Prevention 1600 Clifton Road, NE Mail Stop E-46 Atlanta, GA 30333 Phone:404-639-2090 Fax:404-639-2029

Heterosexual Adults (Women; African Americans, Whites, Hispanics)

The Effects of HIV/AIDS Intervention Groups for High-risk Women in Urban Clinics

Kelly, J.A., Murphy, D.A., Washington, C.D., Wilson, T.S., Koob, J.J., Davis, D.R., Ledezma, G., Davantes, B. (1994). American Journal of Public Health, 84 (12), 1918-1922

Intervention Goal(s): To determine the effects of a small group intervention to reduce high-risk behaviors.

Intervention Setting: Inner-city health clinic.

Population: Of the 197 women who participated in the study, 87% were African American, 3% were Hispanic, 4% were American Indian, and 6% were white. The average age of participants was 29 years, and 97% of the whole group was unemployed. Average education level was some high school.

Comparison Condition: Family and child nutrition intervention.

Description of Intervention: Cognitive-Behavioral Skills Training Group

The intervention incorporated cognitive-behavioral and risk-reduction skills training principles and peer support elements. It consisted of 4 weekly group sessions, 90 minutes each. There were 8 to 10 women in each group. The sessions were conducted in Milwaukee, Wisconsin by 2 female group leaders. The sessions provided detailed information about HIV risk and focused on behaviors that increase risk, common misconceptions about AIDS, and steps to reduce the risk of contracting the disease.

National and local HIV seroprevalence and epidemiology statistics were summarized to personalize risk situations for the women, including the possibility of encountering an infected partner. Exercises emphasized cognitive-attitudinal areas, behavioral skills, and social factors.

Participants role-played initiating discussion of concerns about AIDS and condom use with potential sex partners and resisting sexual pressure from a man whose risk history was unknown or with whom the woman did not want to have sex. Skills-building was a critical component of this intervention. Condom demonstration and practice were provided to desensitize participants to condom use. Also, attention was directed toward recognizing, understanding, and managing one's personal triggers for high-risk behavior.

Behavioral Findings: Women who participated in the intervention reported a significantly greater increase in condom use with their partners and a significantly greater decrease in their frequency of engaging in unprotected sex than women in the comparison condition.

Contact: Jeffrey A. Kelly, Ph.D. Medical College of Wisconsin 1201 North Prospect Avenue Milwaukee, WI 53202 Phone:414-456-7700 Fax:414-287-4209 E-mail: jsherman@post.its.mcw.edu

Heterosexual Adults (Women; African Americans, Whites)

A Community-level HIV Intervention for Inner-city Women: Results of the Women and Infants Demonstration Trial

Lauby, J.L., Smith, P.J., Stark, M., Person, B., Adams, J. (unpublished report).

Intervention Goal(s): To determine the effects of a community-level intervention to increase condom use with main and non-main partners.

Intervention Setting: Street settings, community agencies, organization, businesses, residential complexes, and other community settings.

Population: Interviews were conducted with 3,725 sexually active women of reproductive age in four matched pairs of inner-city communities. In this group of women, 73% were

African American, 20% were white, and 7% were of other racial/ethnic groups; mean age was 25 years.

Comparison Condition: Usual HIV prevention programs available in the community.

Description of Intervention: Women and Infants Demonstration Projects

This community-level intervention was based on the Transtheoretical Model of Behavior Change, which recognizes that change occurs in stages. The intervention aimed to modify attitudes and beliefs about prevention methods among the community women by providing models of successful risk-reduction strategies adopted by members of the target population.

The intervention included 3 components: a media campaign, outreach, and community mobilization. The media campaign included frequent distribution of flyers, brochures, posters, and newsletters that told "role model" stories based on the lives of women in the local community, contained HIV prevention material and referral sources, and furnished other information related to women's physical, social, and economic well-being. The role model stories presented readable and realistic accounts of women in different degrees of readiness to use condoms (i.e., stage-based stories) with either main or non-main partners, how they had overcome barriers or had learned from experience about the need to use condoms, and how they had progressed to more consistent condom use. Media pieces were distributed hand-to-hand or were left at drop sites in businesses, agencies, and meeting places throughout the target communities.

Stage-based outreach was implemented by women from the communities who were either paid a stipend or employed by the project. Outreach was usually one-on-one but was sometimes delivered to groups. The purpose of these interpersonal contacts was to present HIV information and referrals, encourage and reinforce behavior change, and distribute condoms and role model stories.

Community mobilization entailed the recruitment of small businesses, neighborhood organizations, and agencies to donate services or products and to function as sites for distributing role-model stories and displaying posters and other visual materials.

Behavioral/Health Findings: Women in the intervention communities reported a greater increase in consistent condom use with non-main partners than women in the comparison communities.

Contact: Behavioral Intervention Research Branch Division of HIV & AIDS Prevention Centers for Disease Control and Prevention 1600 Clifton Road, MS E-37 Atlanta, GA 30333 Phone: 404-639-1900 Fax: 404-639-1950

Heterosexual Adults (Men; African Americans, Hispanic)

Reductions in STD Infections Subsequent to an STD Clinic Visit

O'Donnell, C.R., O'Donnell, L., San Doval, A., Duran, R., Labes, K. (1998). Sexually Transmitted Diseases, 25 (3), 161-68

Intervention Goal(s): To determine the effects of a small group intervention to reduce sexually transmitted disease (STD) infections subsequent to a clinic visit.

Intervention Setting: STD clinic.

Population: Of the 2004 adult males who participated in the study, 62% were African American and 38% were Hispanic. The average age of the participants was 30 years.

Comparison Condition: Usual services available in the STD clinic.

Description of Intervention: Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)

All participants received STD prevention information, individual counseling, free condoms, and a coupon for condoms as part of their clinic visit for diagnostic and treatment services.

The video-based intervention consisted of a 60-minute session in which participants viewed a 20-minute culturally sensitive video and engaged in a facilitated interactive group discussion. The intervention was delivered to small groups of 3 to 8 men in an STD clinic in the South Bronx, New York City. A trained STD counselor led the discussions.

One video, "Let's Do Something Different," was designed for African Americans and another, "Porque Sí," was developed for Hispanics. Both videos provided accurate risk information and corrected misinformation, portrayed positive attitudes about condom use, and modeled gender and culturally-specific strategies for encouraging condom use. Interactive discussions following the videos aimed to reinforce the STD and HIV prevention messages. Participants addressed problems they had experienced when trying to use condoms and discussed strategies to increase condom use.

Participants were offered a selection of free condoms at the clinic and a coupon for free condoms at an area pharmacy.

Behavioral Findings: Men who participated in the intervention had a significantly lower rate of new STD infection than men in the comparison condition.

Contact: Lydia O'Donnell, Ed. D. Education Development Center, Inc. 55 Chapel Street Newton, MA 02158 Phone: 617-969-7100, ext. 2368 Fax: 617-969-3995 E-mail: lydiaO@edc.org

Heterosexual Adults (Men and Women; African Americans)

Reduction of High-risk Sexual Behavior among Heterosexuals Undergoing HIV Antibody Testing: A Randomized Control Trial

Wenger, N.S., Linn, L.S., Epstein, M., Shapiro, M.F. (1991). American Journal of Public Health, 81 (12), 15 80-15 8 5

Intervention Goal(s): To determine the effects of HIV education and testing to reduce sexual risk behavior.

Intervention Setting: Urban Sexually Transmitted Diseases (STD) clinic.

Population: Of the 186 heterosexual adults who participated in the study, 67% were men and 33% were women; and 88% were African American; 84% had completed high school; and 43% were unemployed. The average age was 28 years, ranging from 18 to 66 years.

Comparison Condition: HIV education only.

Description of Intervention: HIV Education, Testing and Counseling

The intervention was offered to clients of an STD clinic in Los Angeles. The intervention consisted of an educational component and an HIV blood test. The educational component included (a) a written pamphlet that explicitly discussed safer and unsafe sexual acts and explained condom use; (b) a 15-minute video that examined HIV-risk behavior and promoted condom use as well as discussing the risk with sex partners; and (c) a 10-minute, one-on- one counseling session with a physician.

The counseling session focused on assessing personal risk, discussing the elements of HIV testing, and answering any questions about HIV/AIDS or testing.

[NOTE: See Summary for Kamb, et al. for current HIV testing and counseling protocols.]

After completing the educational module, intervention participants had blood drawn for an HIV test. Test results were revealed to intervention participants approximately 2 weeks after study entry and were accompanied by the same risk-reduction message as during the pretest counseling (for seronegative results) or in-depth counseling (for seropositive results).

Behavioral Findings: Participants who received the HIV education and testing intervention reported significantly fewer occurrences of unprotected intercourse than did those in the comparison condition.

Contact: Neil S. Wenger, MD 200 Medical Plaza Suite 420 Los Angeles, CA 90095 Phone:310-206-6232 Fax:310-206-3551 E-mail: nwenger@medicine.medsch.ucla.edu

Men Who Have Sex with Men (Whites, Asians, Pacific Islanders, African Americans)

The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men

Kegeles, S.M., Hays, R.B., Coates, T.J. (1996). American Journal of Public Health, 86 (8), 1129-113 6

Intervention Goal(s): To determine the effects of a community-level intervention to reduce HIV risk behaviors.

Intervention Setting: Mpowerment Center and other community venues where gay men congregated.

Population: Of the cohort of 300 young gay men who were evaluated after 8 months of study, 4% were African American, 7% were Asian or Pacific Islander, 81% were white, and 2% were of other racial/ethnic groups. The average age of the men was 23 years, and the median education level was some college.

Comparison Condition: The intervention was given to comparison communities at a later time.

Description of Intervention: Mpowerment Project

This intervention was based on theories of peer influence and diffusion of innovations, which posit that people are most likely to adopt new behaviors when favorable evaluations of the behavior are conveyed to them by similar others whom they respect.

The intervention was conducted over 8 months and attempted to reach all young gay men in a Eugene, Oregon community. A Core Group of young gay men designed and ran the intervention with input from a Community Advisory Board composed of "elders" from the AIDS, public health, gay and lesbian, and university communities. This engendered a personal commitment to HIV prevention, a sense of ownership of the prevention activities, and a willingness to carry out the activities.

This multi-component intervention included 2 types of formal outreach, informal outreach, peer-led small groups and a small publicity campaign. One type of formal outreach activity was directed at venues where young gay men congregated. Volunteers dressed in costumes and distributed safer-sex materials. Another type of formal outreach activity took place at the Mpowerment Center. It consisted of safer-sex promotional events embedded in a series of fun social activities.

Informal outreach consisted of peer-initiated communications among friends about the need for safer sex. Small groups, called M-Groups, lasted about 3 hours and were designed to be fun and interactive. They served as entry into the project, addressed safer-sex concerns and skills, and motivated participants to invite their friends. The small publicity campaign aimed to reinforce the norms for safer sex and spread awareness of the Mpowerment Project.

Behavioral Findings: Men who participated in the Mpowerment Project reduced their frequency of unprotected anal intercourse significantly more than the men in the comparison community.

Contact: Ben Zovod Center for AIDS Prevention Studies University of California San Francisco 74 New Montgomery, Suite 600 San Francisco, CA 94105 Phone:415-597-9603 Fax:415-597-9213 E-mail: skegeles@psg.ucsf.edu

Men Who Have Sex with Men (Whites, African Americans, Hispanics)

Behavioral Intervention to Reduce AIDS-Risk Activities

Kelly, J.A., St. Lawrence, J.S., Hood, H.V., Brasfield, T.L. (1989). Journal of Counseling and Clinical Psychology, 5 7 (1), 60-67

Intervention Goal(s): To determine the effects of a small group intervention to reduce the frequency of high-risk sexual practices and increase behavioral skills for refusing sexual coercion.

Intervention Setting: An office space associated with a medical center.

Population: Of the 104 gay men who participated in the study, 13% were African American or Hispanic and 87% were white. The average age of the participants was 31 years; 45% had completed college.

Comparison Condition: The intervention was given to comparison participants at a later time.

Description of Intervention: Behavioral Self-management and Assertion Skills

The intervention consisted of 12 weekly group sessions, each about 75 to 90 minutes.

Groups were led by 2 clinical psychologists and 2 project assistants.

Sessions 1-2. AIDS risk reduction. This component included information about AIDS, HIV infection, and HIV-transmission methods.

Sessions 3-5. Behavioral self-management. Participants examined past high-risk sexual activity and identified mood, setting, substance use, and other factors associated with the risk taking. Leaders presented strategies to reduce risk.

Sessions 6-8. Assertion skills training. Three scenarios were used: (a) initiating discussion about one's commitment to low-risk behavior with a potential sex partner; (b) refusing pressures to engage in high-risk behavior; and (c) declining an immediate sexual proposition from a person one wanted to get to know socially.

Sessions 9-11. Relationship skills and social support development. This component addressed strategies for problem solving in relationships and for maintaining low-risk sexual practices, even in committed relationships.

Session 12. Risk-reduction review and identification of useful strategies. This session allowed each participant to address the changes he had made and the strategies he had used.

The intervention used group process, lecture, and role-playing methods to deliver information and develop skills.

Behavioral Findings: Gay men who participated in the intervention reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than the men in the comparison condition.

Contact: Jeffrey A. Kelly, Ph.D. Medical College of Wisconsin 1201 North Prospect Avenue Milwaukee, WI 53202 Phone:414-456-7700 Fax:414-287-4209 E-mail: jsherrnan@post.its.mcw.edu

Men Who Have Sex with Men (Whites, African Americans, Hispanics)

Community AIDS/HIV Risk Reduction: The Effects of Endorsements by Popular People in Three Cities

Kelly, J.A., St. Lawrence, J.S., Stevenson, Y., Hauth, A.C., Kalichman, S.C., Diaz, Y.E., Brasfield, T.L., Koob, J.J., Morgan, M.G. (1992). American Journal of Public Health, 82 (11), 1483-1489

Intervention Goal(s): To determine the effects of a community-level intervention to reduce high-risk behaviors.

Intervention Setting: Gay bars.

Population: Of the 1,469 gay men who completed anonymous baseline and post-intervention surveys in three cities, 9% were African American, 85% were white, and 5% were Hispanic or of other racial/ethnic groups. Average age was 29 years. From the same three cities, 75 gay men of similar race/ethnicity and age were trained as peer leaders.

Comparison Condition: The intervention was given to comparison participants at a later time.

Description of Intervention: Popular Opinion Leader (POL)

This intervention was based on theories of peer influence, behavioral standards and social

norms, and diffusion of innovations. Bartenders at gay clubs in Biloxi, Mississippi, Monroe, Louisiana, and Hattiesburg, Mississippi were enlisted to nominate opinion leaders, i.e., persons who were popular with others. The intervention was delivered in two parts:

Part I. Popular opinion leaders received four sessions, 90 minutes each, of HIV education and communication strategies. A male and a female co-facilitator conducted each session.

Session 1. Epidemiology of HIV, risk and protective behaviors, and misconceptions.

Session 2. Characteristics of effective health promotion messages. Facilitators described ways to sensitize others to the threat of AIDS, stressed that behavior change can prevent AIDS, used self as example, and personally endorsed the benefits of change.

Session 3. Conversational examples of effective health promotion messages. Facilitators modeled conversations and opinion leader participants role-played similar conversations.

Session 4. Real-life conversations and problem solving. Participants reported outcomes of actual conversations (see Part II). Facilitators helped them plan for additional peer conversations.

Part II. Each opinion leader agreed to have at least 14 conversations with peers in the bars about AIDS risk reduction. Opinion leaders wore buttons with a logo that promoted the project and matched posters located in the bars. Buttons were ambiguous and served to trigger conversations.

Behavioral Findings: Men from communities that received the intervention reported a significantly greater reduction in unprotected anal intercourse than the men from the comparison communities.

Contact: Jeffrey A. Kelly, Ph.D. Medical College of Wisconsin 1201 North Prospect Avenue Milwaukee, WI 53202 Phone: 414-456-7700 Fax:414-287-4209 E-mail: jshen-nan@post.its.mcw.edu

Men Who Have Sex with Men (Whites, African Americans, Hispanics, Asians)

AIDS Prevention in Homosexual and Bisexual Men: Results of a Randomized Trial Evaluating Two Risk-Reduction Interventions

Valdiserri, R.O., Lyter, D.W., Leviton, L.C., Callahan, C.M., Kingsley, L.A., Rinaldo, C.R. (1989). AIDS, 3 (1), 21-26

Intervention Goal(s): To determine the effects of an educational intervention program that included skills training in addition to a small group lecture to reduce sexual risk behavior and increase protective behaviors.

Intervention Setting: The office of a community-based organization.

Population: Of the 584 gay and bisexual men who participated in the study, 2% were African American, 95% were white, less than 1% were Hispanic, and less than 1% were Asian. The average age was 33 years, ranging from 19 to 73 years, and 33% of the participants had a college degree.

Comparison Condition: Small group lecture.

Description of Intervention: Small Group Lecture Plus Skills Training

The intervention consisted of a lecture and a skills training session delivered in a 2-session small group format in a community-based organization in Pittsburgh, Pennsylvania. The 60- to 90-minute lecture component, led by a gay health educator, reviewed HIV transmission and the clinical outcomes of HIV infection, the risks of specific sexual practices, the importance of risk reduction through safer-sex practices, correct condom use, and interpretation of HIV antibody tests.

The 140-minute skills-training session was led by a psychotherapist from a community organization that provides counseling services to sexual minorities. The skills-training session included role-playing, psychodrama, and group process to promote the social acceptability of safer sex; strategies to reduce sexual risk behavior; and group discussion on sexuality and relationships among gay men.

Behavioral Findings: Men who participated in the small group lecture plus skills training educational intervention showed a significant increase in condom use for insertive anal intercourse compared to those in the comparison condition.

Contact: Ronald 0. Valdiserri, MD, MPH Centers for Disease Control and Prevention 1600 Clifton Road Mail Stop E-07 Atlanta, GA 30333 Phone:404-639-8002 Fax:404-639-8600 E-mail: ROV1@cdc.gov

Youth (Males; African Americans)

Reductions in HIV Risk-associated Sexual Behaviors among Black Male Adolescents: Effects of an AIDS Prevention Intervention

Jemmott, J.B., Jemmott, L.S., Fong, G.T. (1992). American Journal of Public Health, 82 (3), 372-377

Intervention Goal(s): To determine the effects of a small group intervention to reduce HIV risk behaviors and increase condom use.

Intervention Setting: A local school on a Saturday.

Population: Of the 157 African-American male adolescents who participated in the study, the average age of participants was 15 years; almost all (97%) were enrolled in school.

Comparison Condition: Focused on careers.

Description of Intervention: Be Proud! Be Responsible!

The intervention consisted of one 5-hour session held on a Saturday morning in a local school in Philadelphia, Pennsylvania. The session was led by African-American men and women with backgrounds in human sexuality education, nursing, social work, and small group facilitation. The leaders received 6 hours of training for this intervention.

The intervention included information about risks associated with injection drug use and specific sexual activities. The intervention used videos, games, exercises, and other culturally and developmentally appropriate materials to reinforce learning and to encourage active participation. For example, one video was narrated by an African-American woman and had a multi-ethnic cast. In another activity, "AIDS Basketball," participants formed into teams to earn points for correctly answering factual questions on AIDS. In the exercise, "Uncle Bill's Advice Column," pairs of adolescents wrote a response to a letter to Uncle Bill about AIDS or risky behavior and then read it to the rest of the group for discussion. A condom exercise focused on the correct use of condoms.

The participants also engaged in role-playing situations depicting potential problems in trying to implement safer sex practices, including abstinence.

Behavioral Findings: Adolescents who participated in the intervention reported more frequent use of condoms and fewer sex partners than adolescents in the comparison condition.

Contact: John B. Jemmott III, Ph.D. Department of Psychology O-N-14 Green Hall Princeton University Princeton, NJ 08544-1010 Phone:609-258-4448 Fax:609-258-1113 E-mail: jemmott@Princeton.EDU

Youth (Males and Females; Whites, Hispanics, Asians, African Americans)

Reducing the Risk: Impact of a New Curriculum on Sexual Risk-taking

Kirby, D., Barth, R.P., Leland, N., Fetro, J.V. (1991). Family Planning Perspectives, 23 (6), 253-263

Intervention Goal(s): To determine the effects of a classroom intervention to postpone initiation of sexual intercourse and, among those sexually experienced, to reduce unprotected sex.

Intervention Setting: High school classrooms.

Population: Of the 758 students who participated in the study, 47% were male and 53% were female; 2% were African American, 2% were American Indian, 9% were Asian, 20% were Hispanic, 62% were white, and 5% were of other racial/ethnic groups; 56% were in 10th grade; and about 37% were sexually experienced prior to the study.

Comparison Condition: Usual sexuality instruction available in the school.

Description of Intervention: Reducing the Risk

The intervention was based on social learning, social inoculation, and cognitive behavioral theories. The intervention was carried out in 13 high schools in California. Health education classes offered the 15-session intervention as part of the 10th grade comprehensive health curriculum. Teachers who volunteered to implement the intervention curriculum attended a 3-day training session.

The curriculum included instruction on developing social skills to reduce sexual risk-taking behavior and used role play as a means of practicing and modeling those skills. Numerous activities supported the norm that students should avoid unprotected intercourse, either by not having sex or by using contraceptives.

Students repeatedly role played situations where they recognized various forms of social pressure to have sex, examined the "lines" that young people use to obtain sex, were motivated to resist these pressures, and practiced effective strategies and skills to refrain from sex or unprotected sex. Over the 15 weeks, role plays were less scripted and more oriented to developing student's confidence in their ability to resist pressure. The curriculum also emphasized decision making and assertive communication skills, encouraged students to go to stores and clinics to obtain relevant health information, and required students to ask their parents about their views on abstinence and birth control.

Behavioral Findings: Students receiving the intervention were significantly less likely to initiate sexual intercourse than those in the comparison condition; intervention students who were already sexually experienced were significantly less likely to engage in unprotected intercourse than sexually active students in the comparison condition.

Contact: Nancy Shanfeld, Ph.D. ETR Associates P.O. Box 1830 Santa Cruz, CA 95061 Phone:408-438-4060 Fax:408-438-4618

Youth (Males and Females; Whites, Hispanics, African Americans, Asians)

Preventing HIV Infection Among Adolescents: Evaluation of a School-based Education Program

Main, D.S., Iverson, D.C., McGloin, J., Banspach, S.W., Collins, J.L., Rugg, D.L., Kolbe, L.J. (1994). Preventive Medicine, 23 (4), 409-417

Intervention Goal(s): To determine the effects of a classroom intervention to postpone the initiation of sexual intercourse and to reduce the number of students engaging in unsafe sex and drug-using behaviors.

Intervention Setting: High school classrooms.

Population: Of the 2,015 students who participated in the study, 51 % were male and 49% were female; 6% were African American, 3% were Asian, 21% were Hispanic, 65% were white, and 5% were of other racial/ethnic groups. The average age of the students was 15 years; 60% were in the 9th grade; 44% were sexually experienced prior to the study.

Comparison Condition: Usual program, which was no HIV education or minimal HIV education, as determined by the school districts.

Description of Intervention: Get Real about AIDS (c)1992

This intervention was primarily based on Social Cognitive Theory and the Theory of Reasoned Action. The intervention was implemented in 10 schools in 6 Colorado school districts. The intervention consisted of a 15-session skills-based curriculum, based in part on the program Get Real About AIDS (c) 1992.

Most of the intervention teachers taught health; some taught science, physical education, and study skills. Teachers attended a 5-day (40 hours) training program designed to enhance relevant skills and fidelity of the implementation to the written curriculum.

The curriculum covered the following topics: HIV functional knowledge (that is, knowledge that can be used to reduce risk), teen vulnerability to HIV, normative determinants of risky behavior, condom use, and skills designed to help students

recognize, manage, avoid, or leave risky situations.

Behavioral Findings: Students who participated in the intervention reported fewer sex partners and greater frequency of condom use than students in the comparison schools.

Contact: Deborah S. Main, Ph.D. Department of Family Medicine 1180 Clermont Street Denver, Colorado 80220 Phone:303-315-9700 Fax:303-315-9747 E-mail: debbi.main@uchsc.edu

Youth (Males and Females; African Americans, Hispanics, Whites)

Reductions in HIV Risk among Runaway Youths

Rotheram-Borus, M., Van Rossem, R., Lee, M., Gwadz, M., Koopman, C. (anticipated publication date: 1999).

Intervention Goal(s): To determine the effects of a small group intervention to reduce HIV-related sexual and drug-related risk behaviors.

Intervention Setting: Shelters for runaway adolescents.

Population: Of the 312 runaway and homeless youths who enrolled in the study, 51% were male and 49% were female; 57% were African American, 22% were Hispanic, 16% were white or of other racial/ethnic groups, and race/ethnicity was unknown for 5%. The average age of the youths was 16 years.

Comparison Condition: Usual services available in the runaway shelters.

Description of Intervention: Intensive HIV Prevention for Youths in Runaway Shelters

This intervention was based on Social Learning Theory, using small groups (a) as practice and role-play opportunities, (b) to mobilize and reinforce positive behaviors, and (c) to maintain support networks. The intervention consisted of 10 group sessions on a rotating basis, 3 times per week, repeated every 4 to 6 weeks, and one individual counseling session. Sessions were led by trained counselors in shelters for runaway youth in the New York City area. The intervention had four primary components:

1. HIV-related knowledge. Activities included video and art workshops where youth developed soap opera dramatizations, public service announcements, commercials, and raps about HIV prevention, and they reviewed and discussed commercial HIV/AIDS prevention videos.

2. Social skills. Training on assertiveness and coping skills, including use of a "feeling thermometer," were employed to develop skills for use in HIV-risk situations.

3. Access to resources. Participants visited a community-based comprehensive health and mental health center.

4. Personalized beliefs, attitudes and norms. Participants had a private counseling session during which they could assess individual barriers to practicing safer sex and discuss their own attitudes and behavior patterns. Dysfunctional attitudes and behavior patterns were targeted.

Incentives included food and $1 for carrying condoms and arriving to the program on time.

Behavioral Findings: Adolescents who participated in the intervention reduced both the number of unprotected sexual acts and their substance use significantly more than adolescents in the comparison shelters.

Contact: Mary Jane Rotheram-Borus, Ph.D. Department of Psychiatry University of California Los Angeles 10920 Wilshire Blvd, Suite 350 Los Angeles, CA 90024 Phone:310-794-8280 Fax:310-794-8297 E-mail: rotheram@ucia.edu

Youth (Males and Females, African Americans)

A Randomized, Controlled Effectiveness Trial of an AIDS Prevention Program for Low-income African-American Youths

Stanton, B.F., Li, X., Ricardo, I., Galbraith, J., Feigelman, S., KaIjee, L. (1996). Archives of Pediatrics and Adolescent Medicine, 150 (4), 363-372

Intervention Goal(s): To determine the effects of a peer network decision-making intervention to increase condom use among sexually active youth.

Intervention Setting: Recreation centers associated with public housing developments; rural campsite setting.

Population: Of the 383 African-American youths who participated in the study, 56% were male and 44% were female. The average age was 11 years, and 78% were aged 9 through 12 years; 36% were sexually experienced prior to the study. C,

Comparison Condition: Individual youth attended weekly sessions, which included a movie with AIDS facts, discussion, and access to condoms.

Description of Intervention: Focus on Kids

The intervention, developed through ethnographic research, targeted pre- and early-adolescents in their existing friendship groups. Being in such a group was a requirement of enrollment. AIDS prevention education was based on a social cognitive model, Protection Motivation Theory (PMT), that uses cost and reward constructs to explain how intentions are formed to respond to threats in either

adaptive or maladaptive ways.

The intervention consisted of 8 sessions: seven 1 1/2-hour weekly meetings at local recreational centers and one day-long session at a rural campsite. The intervention was delivered in a large Eastern city to peer groups that consisted of 3 to 10 same-gender friends within 3 years of age of each other. The sessions were led by a pair of interventionists, at least one of whom was gender matched to the group.

Most of the interventionists were African-American men and women recruited from the community. Each session focused on one or more PMT concepts and also reviewed concepts from the C prior session. Beginning in the first session and integrated throughout, a family genogram was used to illustrate the application of concepts to real-life situations.

Sessions emphasized values clarification and goal setting; presented facts regarding AIDS, STDs, contraception, and human development; and provided condoms. Multiple delivery formats were used to address individual variability in receptivity to media, e.g., videos, games, role-playing, acting, storytelling, and arts and crafts. In the seventh session, participants developed community projects with specific target audiences and intervention messages. The eighth session included a presentation of the projects and concluded with a "graduation" ceremony.

Behavioral Findings: Sexually active youth who participated in the intervention reported significantly greater condom use than sexually active youth in the comparison condition.

Contact: Bonita Stanton, MD 41 Department of Pediatrics University of Maryland at Baltimore 700 West Lombard Street Baltimore, MD 21201 Phone:410-706-5289 Fax:410-706-0653 E-mail: bstanton@umabnet.ab.umd.edu

Youth (Males and Females; African Americans)

Cognitive-Behavioral Intervention To Reduce African-American Adolescents' Risk for HIV Infection

St. Lawrence, J.S., Brasfield, T.L., Jefferson, K.W., Alleyne, E., O'Bannon, R.E., Shirley, A. (1995). Journal of Consulting and Clinical Psychology, 63 (2), 221-237

Intervention Goal(s): To determine the effects a small group intervention to reduce sexual risk.

Intervention Setting: A public health clinic serving low-income families.

Population: Of the 246 inner city African-American youths who enrolled in the study, 28% were male and 72% were female. The average age was 15 years, ranging from 14 to

18 years; the average school grade was 10; and 3 6% were sexually experienced prior to the study.

Comparison Condition: Received Session 1 only.

Description of Intervention: Becoming A Responsible Teen (BART)

This intervention is based on social learning theory and stresses attention to participants'

informational needs, motivational influences, and behavior (IMB), from the IMB risk-reduction model. The intervention consisted of 8 weekly educational and behavior skills sessions of 90 to 120 minutes each. Two co-facilitators, a male and a female, led the sessions in a small group format.

The intervention was conducted in a comprehensive health center that serves predominantly low-income minority clients in a Mississippi city of 400,000 residents.

Session 1 AIDS education. HIV/AIDS information, presented in the context of local HIV/AIDS demographics, was interspersed with games, group discussion, and other activities.

Session 2 Sexual decisions and values. Group discussion about sexual decisions and pressures was followed by a video for African-American youths, Seriously Fresh, and video discussion.

Session 3 Technical competency skills. Discussion of statewide adolescent sexual activity levels was followed by condom use demonstrations, small group practice, and cognitive restructuring of unhelpful beliefs about self-protection and condom use.

Session 4-6 Social competency skills. Communication skills and assertiveness were taught in 3 contexts: a) initiating discussion about condoms in advance with a sex partner, b) refusing pressure to engage in unprotected sex, and c) sharing HIV-risk information with peers. Leaders demonstrated these skills, followed by participant role play.

Session 7 Cognitive competency skills. Local HIV-seropositive youths, the "Rap Team," discussed how HIV had affected their lives. Behavioral self-management and problem solving strategies, especially those used successfully in the past, were the focus of sessions 7 and 8.

Session 8 Social support and empowerment. Participants shared what each felt was most helpful in BART and the personal changes each had made in response to participating in BART. The impact the group could have by educating friends and families was illustrated and the importance of supportive friendship networks was stressed.

Incentives included $5 an hour for participation, a project T-shirt for attending all sessions, and a personalized certificate of completion at the final session.

Behavioral Findings: Youths who participated in the intervention reported significantly greater condom use and significantly lower frequency of unprotected intercourse than youths in the comparison condition. Abstinent youth who participated in the intervention

significantly delayed sexual onset to a greater extent than abstinent youth in the comparison condition.

Contact: Janet S. St. Lawrence, Ph.D. Phone:404-829-8298 Centers for Disease Control and Prevention Fax:404-829-8622 1600 Clifton Road, Mail Stop E-44 E-mail: nzs4@cdc.gov Atlanta, GA 30333

HIV Prevention Interventions that have worked for At-Risk Populations

IDUs	Source of Information
Group-level interventions	• Susser E, Valencia E, Torres J. Sex, games and videotapes: an HIV-prevention intervention for men who are homeless and mentally ill. Psychosocial Rehabilitation Journal. 1994;17:31-40. • Martin SS, Butzin CA, Inciardi JA. Assessment of a multistage therapeutic community for drug-involved offenders. Journal of Psychoactive Drugs. 1995;27:109-116. • Des Jarlais, D.C., Casriel, C., Friedman, S.R., & Rosenblum, A. (1992). **Compendium* P. 4.43** • El-Bassel, N. & Schilling, R.F. (1992). **Compendium* P. 4.44** • Magura, S., Kang, S., & Shapiro, J.L. (1994). **Compendium* P. 4.45** • McCusker, J., Stoddard, A.M., Zapka, J.G., Morrison, C.S., et al. (1992). **Compendium* P. 4.46**
Outreach (including needle exchange programs)	• Interventions to Prevent HIV Risk Behaviors, National Institutes of Health, Consensus Development Statement, February 11-13, 1997 • The Effectiveness Of AIDS Prevention Efforts, Congressional Office of Technology Assistance • CDC AIDS Community Demonstration Projects Research Group (1999) **Compendium* P. 4.41**
MSM	**Source of Information**
Group-level interventions	• Interventions to Prevent HIV Risk Behaviors, National Institutes of Health, Consensus Development Statement, February 11-13, 1997 • The Effectiveness Of AIDS Prevention Efforts, Congressional Office of Technology Assistance • Does Prevention Work for Gay Men? Center for AIDS Prevention Studies, University of California San Francisco, June 1998. • Kelly, J.A., St. Lawrence, J.S., Hood, H.V., & Brasfield, T.L. (1989). **Compendium* P. 4.59** • Valdiserri, R.O., Lyter, D.W., Leviton, L.C., Callahan, C.M., et al. (1989). **Compendium* P. 4.60**

Health communications / Public information (Programs aimed at changing community norms)	• Interventions to Prevent HIV Risk Behaviors, National Institutes of Health, Consensus Development Statement, February 11-13, 1997 • The Effectiveness Of AIDS Prevention Efforts, Congressional Office of Technology Assistance • Does Prevention Work for Gay Men? Center for AIDS Prevention Studies, University of California San Francisco, June 1998. • Coates, 1995; Kegeles, Hays, & Coates, in press • Kegeles, S.M., Hays, R.B.,& Coates, T.J. (1996). **Compendium* P. 4.56**
Individual-level interventions	• The Effectiveness Of AIDS Prevention Efforts, Congressional Office of Technology Assistance • Does Prevention Work for Gay Men? Center for AIDS Prevention Studies, University of California San Francisco, June 1998.
Outreach	• Kegeles, S.M., Hays, R.B.,& Coates, T.J. (1996). **Compendium* P. 4.56** • Kelly, J.A., St. Lawrence, J.S., Stevenson, Y., Hauth, A.C., et al. (1992). **Compendium* P. 4.58** • CDC AIDS Community Demonstration Projects Research Group (1999) **Compendium* P. 4.41**
AA gay/bisexual men	**Source of Information**
Group-level interventions	• Peterson, Coates, Hauck, et al., no date • African-American Men's Health Study: Gay and Bisexual Men, 1998
Young gay/bisexual men	**Source of Information**
Outreach	• Stall R, Barrett D, Bye L, et al. A comparison of younger and older gay men's HIV risk-taking behaviors: The Communication Technologies 1989 Cross-Sectional Survey. Journal of Acquired Immune Deficiency Syndromes. 1992; 5:682-687. • Kegeles, S.M., Hays, R.B., & Coates, T.J. (1996). **Compendium* P. 4.56**
Group-level interventions	• Kegeles, S.M., Hays, R.B., & Coates, T.J. (1996). **Compendium* P. 4.56**
Other (community outreach, community mobilization)	• Stall R, Barrett D, Bye L, et al. A comparison of younger and older gay men's HIV risk-taking behaviors: The Communication Technologies 1989 Cross-Sectional Survey. Journal of Acquired Immune Deficiency Syndromes. 1992; 5:682-687.

Gay/bisexual Asians & Pacific Islanders	Source of Information
Outreach	• Yep GA. HIV/AIDS in Asian and Pacific Islander communities in the US: a review, analysis and integration. International Quarterly of Community Health Education. 1993; 13:293-315. Contact: Gust Yep, (415) 338-2268.
Group-level interventions	• Choi K-H, Lew S, Vittinghoff E et al. The efficacy of brief group counseling in HIV risk reduction among homosexual Asian and Pacific Islander men. AIDS. 1996; 10:81-87. Contact: API Wellness Center, Technical Assistance, 415/292-3420 X327.
Gay/bisexual Hispanic/Latino men	**Source of Information**
Group-level interventions	• Assessment of the HIV Prevention Needs of Gay/Bisexual Latino Men in the District of Columbia. Salud, Inc., 1996 • Carballo-Dieguez A; Dolezal C. HIV Risk in New York City's Homosexually Active Latin American Men. 1997. • Díaz RM. HIV risk in Latino gay/bisexual men: a review of behavioral research. Report prepared for the National Latino/a Lesbian and Gay Organization. 1995. Contact for Hermanos de Luna y Sol: Jose Ramón Fernández-Peña, Mission Neighborhood Health Center, 415/552-1013 X386.
Heterosexual women	**Source of Information**
Group-level interventions	• Interventions to Prevent HIV Risk Behaviors, National Institutes of Health, Consensus Development Statement, February 11-13, 1997 • The Effectiveness Of AIDS Prevention Efforts, Congressional Office of Technology Assistance • Coley BI, Sikkema KJ, Perry MJ, et al. The role of women as opinion leaders in a community intervention to reduce HIV risk behavior. National Conference on Women and HIV, Pasadena, CA. 1997; Abstract #206.3. Contact: Brenda Coley 414/456-7746 • Collaborative programs in prison HIV prevention. Contact: Barry Zack, Centerforce, Health Programs Division, San Quentin, CA: 415/456-9980.

	• El-Bassel & Schilling 1992 • Smith, Strand, & Smith, 1994
Outreach	• Tross, Abdul-Quader, Simons, et al., 1993
African American women	**Source of Information**
Outreach	• Mackey JL; Wilburn-Sines V. Innovative education techniques targeting African American women. Int Conf AIDS. 1996 Jul 7-12; 11(1): 407 (abstract no. Tu.D.2859). Office of HIV Services, Fairfax, VA. • Lauby, J.L., Smith, P.J., Stark, M., Person, B., & Adams, J. (1998). **Compendium* P. 4.53**
Group-level interventions	• DiClemente, R.J., & Wingood, G.M. (1995). **Compendium* P. 4.49** • Hobfoll, S.E., Jackson, A.P., Lavin, J., Britton, P.J., & Shepherd, J.B. (1994). **Compendium* P. 4.50** • Kelly, J.A., Murphy, D.A., Washington, C.D., Wilson, T.S., et al., (1994). **Compendium* P. 4.52**
Health Communications / Public Information	• Lauby, J.L., Smith, P.J., Stark, M., Person, B., & Adams, J. (1998). **Compendium* P. 4.53**
Other (community mobilization)	• Lauby, J.L., Smith, P.J., Stark, M., Person, B., & Adams, J. (1998). **Compendium* P. 4.53**
Hispanic/Latina	**Source of Information**
Group-level interventions	• Marín BV; Gomez CA; Grinstead OA. The gender gap: what young unmarried Latinos think & do about sex. Int Conf AIDS. 1994 Aug 7-12; 10(1): 15 (abstract no. 034D). Ctr. for AIDS Prevention Studies, University of California, San; Francisco.
Heterosexual men	**Source of Information**
Group-level interventions	• Marin BV, Gomez C, Tschann J, et al. Traditional gender role beliefs increase sexual coercion and lower condom use in US Latino men. Presented at the 11th International Conference on AIDS, Vancouver, BC. 1996. Abstract We.C.3519. • O'Donnell, C.R., O'Donnell, L., San Doval, A., Duran, R., & Labes, K. (1998). Compendium *. P. I-14

Individual-level interventions	• Men-new focus for family planning programs. Population Reports. 1986; Series J: 879. • O'Donnell, C.R., O'Donnell, L., San Doval, A., Duran, R., & Labes, K. (1998). Compendium *. P. I-14
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Heterosexual men and women	**Source of Information**
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* Compendium refers to the CDC's "Compendium of HIV Prevention Interventions with Evidence of Effectiveness," which starts on **Page ??.**

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Cost Effectiveness of HIV Prevention Programs

The Centers for Disease Control and Prevention (CDC) encourages HIV prevention community planning groups to consider cost effectiveness in their intervention priority-setting activities. Cost-effectiveness analysis can help decision makers pull together into a single analysis a variety of bits of information about program costs and effectiveness, as well as to confront any uncertainty they might have about programs' costs and consequences. In the past, trying to do this was frustrating because studies specifically on this topic were relatively scarce. Today, however, there are several new studies available on the cost effectiveness of HIV prevention.

Counseling and Testing: An assessment of the economic costs and benefits of CTRPN (Holtgrave et al., 1993) concluded that, "Even under conservative assumptions, the CDC's expenditure on HIV CTRPN services results in a substantial net economic benefit to society." That is, given the projected number of HIV infections that would be prevented by CTRPN, the cost to society of providing the services is less than the savings incurred. This same report, however, points out that this strategy provides more net economic benefits in higher-prevalence populations than in lower-prevalence populations, since a greater number of HIV infections will be prevented by CTRPN in a population with a high prevalence of HIV.

Owens and co-workers (1) evaluated the cost-effectiveness of CDC's recommendation to screen for HIV infection in acute care settings where the seroprevalence of HIV infection is 1 percent or more. When measuring only the costs and benefits associated with the person screened, the cost-effectiveness of screening was $60,000 per life year saved at 1 percent seroprevalence, and ranged from $71,000 to $55,000 per life year saved at 0.5 to 2 percent seroprevalence (1). This cost per life year saved is near the cutoff usually considered cost-effective for screening strategies (2). These cost-effectiveness ratios appear less favorable than the cost-saving results for publicly funded HIV CTRPN because of the lower HIV seroprevalence of the acute-care settings relative to the CTRPN sites and perhaps different study assumptions and methods.

Partner notification has been shown to be an effective and cost efficient program. HIV partner notification targets persons who have been exposed to HIV. This presents an opportunity to inform persons who are sometimes unaware of their individual risk that they are at risk.

Holtgrave and co-workers conducted a cost- benefit analysis of publicly funded HIV CTRPN programs (3). They estimated this program's direct and indirect costs, number of persons served, approximate number of HIV infections averted, monetary benefits to society for each HIV infection averted, and benefit-cost ratios. Under base-case assumptions, the benefit-cost ratio was slightly more than 20 (every dollar invested in HIV CTRPN yielded a $20 gain), and greater than one for all cases considered (64).

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Group Interventions for Heterosexual Women: A paper published in the American Journal of Public Health that examined the cost effectiveness of a behavioral HIV prevention intervention for at-risk women attending urban primary health care centers. The intervention consisted of five sessions covering basic HIV-related information, condom-use skills training, peer support, self-management, and assertiveness, communications, and negotiation in sexual situations. Clients receiving this intervention used condoms significantly more often than clients not receiving the intervention did.

Although the intervention cost approximately $260 per client, careful analysis shows that the increases in condom use likely led to a reduction in HIV transmission (and when HIV infections are avoided, medical costs of care and treatment are saved). Therefore, cost-effectiveness analysis shows that even this multi-session intervention appears to be a cost-effective use of resources.

Group Interventions for Gay Men: A community intervention for young gay men in Eugene, Oregon used a variety of social, outreach, and small group activities designed and run by peers to help lower rates of unprotected anal intercourse. (1) This successful program is estimated to cost about $11,000 per HIV infection prevented.

At the XI International Conference on AIDS in July, a poster was presented that showed the cost effectiveness of a 12-session behavioral HIV prevention intervention for gay men that included HIV education, condom skills training, and self-management and communications techniques. This intervention cost approximately $470 per client. However, the intervention led to a significant increase in condom use. Such an increase is very likely to have significantly reduced HIV transmission among intervention clients and their partners, according to epidemiological models. A rigorous analysis shows that the public health benefits of this intervention result in substantial cost savings to society.

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Outreach for Gay Men: These programs are very cost effective when the purposes are limited to the distribution of information to a relatively large number of people and affecting community norms. Outreach is not an effective approach to behavior modification, though it can be the base for such efforts. A program that trained community leaders to deliver AIDS risk-reduction messages to their peers in gay bars resulted in a decrease in unprotected anal sex. (1)

Because the program has relatively low costs, the estimated cost per HIV infection prevented is $12,000, which is much lower than the $119,000 lifetime cost of treatment. (2)

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Outreach to Injecting Drug Users: Wiebel and colleagues (1) concluded that street-based outreach services (and use of indigenous outreach workers) were cost-effective alternative interventions for preventing HIV infection among IDUs. They estimated that a street outreach program in the Chicago area prevented 82 new HIV infections among 641 IDUs over a 4-year period, which would have cost more than $9.7 million to treat from infection to death. Under this program, the cost per individual IDU contact was $30, and the cost per HIV infection prevented ranged from $150 to $300 (1).

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Prevention Case Management for IDUs: James Kahn, MD, MPH, cites one study that found extensive counseling for IDUs in East Coast cities to be cost effective. The cost per HIV infection averted was estimated to be between $3,500 and $4,000, which is substantially less than the estimated costs of medical care for someone with HIV/AIDS.

Counseling and testing, extended counseling and education (after counseling and testing), partner notification, bleach distribution, and treatment of drug dependency for IDUs: One study estimated the cost-effectiveness of these five HIV prevention interventions for IDUs. (1). For each intervention, the cost per adult HIV infection averted was calculated using only the direct costs associated with implementing the intervention in two sample cities in the eastern United States with moderate-to-high HIV risk levels. Cost per adult HIV infection averted for the first four interventions ranged from about $3,000 to $32,000 in City A and $4,000 to $66,000 in City B, with partner notification being the most expensive. Treatment of drug dependency provided additional HIV-related benefits of $5,000 to $7,000 per treatment slot per year (1).

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Partner Counseling and Referral Services: Although the relative investment per person reached might be greater than other public health activities, PCRS is likely to be highly cost-effective. A simple threshold analysis illustrates the probable cost-effectiveness of PCRS to society. Assuming an estimated current $154,402 lifetime cost in the United States of a person acquiring HIV infection and eventually dying from HIV-related illness (Holtgrave and Pinkerton, 1997) and a conservatively estimated average $3,205 cost of PCRS to reach one infected person (Toomey *et al.*, 1998).

PCRS must prevent 1 infection out of every 51 HIV-infected partners reached through PCRS to be cost-effective. As PCRS links HIV-infected partners to client-centered counseling and other interventions proven or likely to be effective, this appears to be a threshold relatively easy to achieve by programs. Greater effectiveness, such as preventing only 2-3 infections for every 51 HIV-infected partners reached through PCRS, would convey substantial cost savings to society.

Hotlines: Hotlines are rarely inexpensive to run and maintain particularly when they exist to serve wide geographic regions. On the other hand, their per unit cost is low if volunteers are utilized to provide most of the actual answering of phone lines. (1) While the direct impact of hotlines on averting new HIV infections is uncertain, they are probably cost effective even if they avert only a few infections.

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Perinatal Transmission: Recent findings on the effectiveness of using prenatal, perinatal, and postnatal zidovudine therapy to prevent perinatal HIV transmission led the Public Health Service to recommend routine HIV counseling and voluntary testing for all pregnant women. (1) A paper published in 1999 directly analyzed the cost effectiveness of those recommendations. This analysis found that HIV counseling and voluntary testing for pregnant women (and zidovudine therapy for those found to be infected with HIV) would actually be cost saving to society.

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Using Theory in HIV Prevention

Center for AIDS Prevention Studies at the University of California San Francisco

Whether or not it is stated, some form of theory is already the basis of prevention interventions. Prevention planners know their populations and have ideas about what determines client behaviors as well as their strengths and needs as individuals and as a community. This hands-on knowledge about what works is informal theory.

Formal theory is made up of principles and methods about prevention and behavior change that have already proven useful in some areas of disease prevention and behavior change. Theories can give HIV program planners a framework for the goals of an intervention, or help explain aspects of risk-taking behavior when working with a new population. Using theories to design HIV prevention interventions can help improve programs, saving valuable time and resources. (1)

What are some theories?

Theory is one of many tools that can have an important influence on HIV prevention programs. Some of the most widely known theories are presented below. These theories are not mutually exclusive, but can work together to guide effective programs.

Health Belief Model proposes that an individual's actions are based on beliefs. (2) It identifies key elements of decision making such as the person's perception of susceptibility, perceived severity of the illness, and the perceived barriers to prevention.

Theory of Reasoned Action sees intention as the main influence on behavior. (3) Intentions are a combination of personal attitudes toward the behavior as well as the opinions of peers, both heavily influenced by the social milieu.

Social Cognitive Theory views learning as a social process influenced by interactions with other people. (4) In Social Cognitive Theory physical and social environments are influential in reinforcing and shaping the beliefs that determine behavior. A change in any of the three components — behavior, physical or social environments — influences the other two. Self-efficacy, an essential component of the theory, is the person's belief that s/he is capable of performing the new behavior in the proposed situation.

AIDS Risk Reduction Model suggests that in order to change behavior one must first label the behavior as risky, then make a commitment to reduce the behavior, and finally to take action to perform the desired change. (5) Factors influencing movement between these stages include fear/anxiety and social norms.

Diffusion of Innovation helps understand how new ideas or behaviors are introduced and become accepted by a community. People in the same community adopt new behaviors at different rates and respond to different methods of intervention. (6)

Stages of Change explains the process of behavior change, from not being aware of the negative effects of a behavior, to maintaining safer behaviors. (7) The five stages are: Precontemplation, Contemplation, Preparation, Action and Maintenance. Different stages exist in the same population. People do not necessarily pass through stages sequentially and may repeat stages.

Harm Reduction accepts that while harmful behaviors exist, the main goal is to reduce their negative effects. (8) HR examines behaviors and attitudes of the individual to offer ways to decrease the negative consequences of the targeted behavior.

Paulo Freire's ideas on **Popular Education** are based on the belief that teachers and students have different strengths, and should learn reciprocally from each other. (9) Group discussions examine problems and develop solutions to personally empower people to change their environment, thereby influencing their subsequent actions.

How is theory used in practice?

Just as people draw from a variety of influences for their actions, programs can be designed or modified using relevant parts of different theories.

A school-based program targeting African-American male adolescents in Philadelphia, PA used Reasoned Action and Social Cognitive theories. A five-hour session included discussion, games, role-playing, videos, and other activities. The session targeted self-efficacy through role-playing, and peer norms through a variety of exercises. Follow-up after three months showed less sexual risk-taking and higher maintenance of safer sex intentions since the intervention. (10)

Guided by Diffusion of Innovation, one mid-western project used bartenders at gay bars in several medium-sized towns to help identify the most popular people. These people were trained to deliver AIDS risk-reduction messages to their friends and acquaintances in the bars. Patrons encouraged by the role modeling of these popular community members were found to have fewer instances of unsafe sex. (11)

In a sexually transmitted disease clinic in New York, a video-based educational intervention was planned through the use of the Theory of Reasoned Action and Social Cognitive Theory. The culturally sensitive videos were effective in increasing condom purchases among both men and women and even more effective with the addition of interactive group sessions following the videos (a 74% increase over the control group). The videos targeted norms, attitudes, and behaviors that were reducing the effectiveness of current sexually transmitted disease prevention efforts. The intervention was effective by providing information to overcome barriers to safe sex, discussing issues around condom use, and practicing condom-negotiating skills. (12)

MenTalk, a program for gay men in Oregon, uses a Popular Education approach, gathering groups of gay men and a volunteer facilitator to discuss barriers and solutions to issues about HIV testing, safer-sex and community involvement. The program helped raise consciousness and encouraged the participants to make HIV prevention behavior changes at both the personal and the community level. (13)

Using the Harm Reduction model and the principles of Freirean empowerment, needle exchange programs across the country aim to decrease the transmission of HIV infection in injection drug users. Programs may offer clean needles, bleach, condoms, as well as referrals to treatment programs. By working with clients whether they intend to continue using drugs or not, these programs build trust and assist clients to decrease the risk of HIV infection. (14)

A program targeting recently released male and female parolees with a history of drug injection used Social Cognitive Theory to develop an AIDS prevention training. By using

ideas of community building, individual responsibility, role models, and job training as outreach workers, the environment in which behaviors would be determined was modified. After one year, participants had significantly decreased certain sexual and drug risk taking and also improved their adjustment to the community. (15)

What needs to be done?

New theories arise from a variety of sources, often from the community that sees the need. Collaborations between service organizations and researchers need to be encouraged, so that programs move beyond learning through word of mouth. A comprehensive HIV prevention strategy uses multiple elements to protect as many of those at risk of HIV infection as possible. Using theory as a framework, planners can take a closer look at what works in prevention and design more effective programs and lay the groundwork for program evaluation. This synthesis can result in more effective programs that better reach people at risk, and can help save time, money and lives.

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Guidance and Standards for HIV Prevention Interventions

Department of Health

Administration for HIV/AIDS

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Introduction

The purpose of this document is to provide guidance and standards on the implementation of primary HIV prevention interventions. [The Centers for Disease Control and Prevention (CDC) defines primary prevention as "halting the transmission or acquisition of HIV infection"].

Standards are provided in several sections. These standards should be applied consistently in the delivery of HIV prevention interventions. They must be followed in virtually all cases.

This document provides overall **guidance** in developing and implementing HIV prevention interventions. The overall is intended to be more flexible than the **standards**, and should be followed in most cases. The Administration for HIV/AIDS (AHA) recognizes that, depending on the client population, setting, and other factors, the overall guidance can and should be tailored to fit individual program needs.

AHA will evaluate the design of HIV prevention interventions before they are implemented to ensure that they follow this guidance and the standards set for several interventions. The information is listed in the order it appears in the following table, which was developed by the Centers for Disease Control and Prevention for its Evaluation Guidance.

Intervention Types Used in CDC' s Evaluation Guidance

A. Individual-level Interventions (ILI) **Example/s:** Individual prevention counseling (not related to counseling and testing)	Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. **Note**: According to a strict categorization, outreach and prevention case management also are individual-level interventions. However, for the purposes of this reporting, ILI does *not* include outreach or prevention case management, which each constitutes their own intervention categories.
B. Group-level Interventions (GLI) **Example/s:** Psycho-educational skills-building groups	Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide-range of skills, information, education, and support. **Note**: Many providers may consider general education activities to be group-level interventions. However, for the purposes of this reporting, GLI does *not* include "one-shot" educational presentations or lectures (that lack a skills component). Those types of activities should be included in the Health Communication/Public Information category.
C. Outreach **Example/s:** Street and/or bar outreach Needle exchange programs	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients' typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.

D. Prevention Case Management (PCM)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.
E. Partner Counseling and Referral Services (PCRS)	A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.
F. Health Communications/Public Information (HC/PI) **Example/s:** Presentations/Lectures ("one-shot" education interventions)	The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. **Electronic Media:** Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience. **Print Media:** These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage. **Hotline:** Telephone service (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups. **Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations. **Presentations/Lectures:** These are information-only activities conducted in group settings; often called "one-shot" education interventions.
G. Other Interventions **Example/s:** Social Marketing Community Mobilization Community-wide events (such as health fairs)	Category to be used for those interventions funded with CDC Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions (example forms A-F). This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

General Considerations Regarding HERR Activities

From “Guidelines for Health Education and Risk Reduction (HERR) Activities”

US Department of Health & Human Services
Public Health Service
Centers for Disease Control and Prevention
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Introduction

Preventing the spread of human immunodeficiency virus (HIV) and sexually transmitted disease (STD) requires a comprehensive strategy composed of service delivery systems coupled with effective, sustained health education and health promotion interventions. These individual components of a prevention program must not operate in isolation, but must work together toward the well-being of the person at risk and the community as a whole. All education activities related to HIV/STD prevention should contribute to and complement the overall goal of reducing high-risk behaviors.

The guidelines presented in this document are written to encourage HIV/STD prevention programs to focus on developing programs and services that are based on health education and health promotion strategies. In Health Behavior and Health Education: Theory, Research, and Practice, the authors describe the ultimate aims of health education as being "positive changes in behavior" (Glanz et al., 1990, p.9). Green and Kreuter further define health promotions as ". . . the combination of educational and environmental supports for actions and conditions of living conducive to health" (Green and Kreuter, 1991). Health education is a powerful tool in an epidemic in which the behavior of using a latex condom can make the difference in whether or not a person becomes infected with HIV.

It is critically important that members of the populations to be served are involved in identifying and prioritizing needs and in planning HIV/STD education interventions. Their involvement ensures that decisions are made, purposes are defined, intervention messages are designed and developed, and funds are allocated in an informed and realistic manner. Limited educational resources can be proactively directed to specific populations, rather than reactively directed or directed on the basis of guesswork or stereotyping.

Moreover, to be effective, an education intervention must be culturally competent. Participation of client populations throughout the process of designing and implementing programs helps assure that the program will be acceptable to the persons for whom it is intended. For the purposes of this document, cultural competence is defined as the capacity and skill to function effectively in environments that are culturally diverse and that are composed of distinct elements and qualities. Cultural competence begins with the HIV/STD professional understanding and respecting cultural differences and understanding that the clients' cultures affect their beliefs, perceptions, attitudes, and behaviors.

Health departments across the country have implemented an HIV prevention community planning process whereby the identification of a community's high priority prevention needs is shared between the health departments administering HIV prevention funds and representatives of the communities for whom the services are intended. The HIV prevention community planning process begins with an accurate epidemiologic profile of the present and future extent of HIV and acquired immunodeficiency syndrome (AIDS) in the jurisdiction. Special attention is paid to distinguishing the behavioral, demographic, and racial/ethnic characteristics of the epidemic. This is followed by an assessment of HIV prevention needs that is based on a variety of sources and is collected using different assessment strategies. Next, priorities are established among needed HIV prevention strategies and interventions for specific populations. From these priorities, a comprehensive HIV prevention plan is developed.

Of the eight essential components of a comprehensive HIV prevention program that are described in the community planning guidance document issued by CDC, four relate specifically to the interventions described in these Guidelines. These are as follows:

- Individual level interventions which provide ongoing health communications, health education, and risk reduction counseling to assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices which prevent transmission of HIV, and they help clients make plans to obtain these services.
- Health communications, health education, and risk reduction interventions for groups, which provide peer education and support, as well as promote and reinforce safer behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change.
- Community level interventions for populations at risk for HIV infection, which seek to reduce risk behaviors by changing attitudes, norms, and practices through health communications, prevention marketing, (1) community mobilization/organization, and community-wide events.
- Public information programs for the general public, which seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention in the community.

(More information on the HIV prevention community planning process is contained in the Handbook for HIV Prevention Community Planning (Academy for Educational Development, 1994) or from the HIV/AIDS Program in your local health department. All HIV health education and risk reduction activities should complement and support the priorities established in the HIV prevention comprehensive plan developed by the local HIV prevention community planning group.)

For the purpose of this document, communities are defined as social units that are at least one of the following: functional spatial units meeting basic needs for sustenance, units of patterned social interaction, or symbolic units of collective identity (Hunter, 1975). Communities are selected for interventions based on their specific and identified needs and on surveillance and seroprevalence data.

The recommendations in this document recognize that while communities may have different approaches to HIV/STD prevention programs, certain basic programmatic, management, and staff requirements are common to effective health education and risk reduction activities. These Guidelines describe the core elements that are essential for success in a number of types of health education and risk reduction activities – Individual and Group Interventions and Community-level Interventions – and in public information activities.

These guidelines are provided to assist program planners in enhancing their health education and risk reduction activities. In some cases, specific programs of state and local health departments have advanced beyond the basic steps outlined here. In other instances, programs may benefit greatly from these

suggestions. The priority activities described in this document can be used in a variety of settings and can also be applied to other health issues.

(1) Prevention marketing is CDC's adaptation of social marketing in which science-based marketing techniques and consumer-oriented health communication technologies are combined with local community involvement to plan and implement HIV/AIDS prevention programs. Essentially, prevention marketing = social marketing + community involvement.

Core Elements of Health Education and Risk Reduction Activities

A number of core elements should be considered in health education and risk reduction program and evaluation activities.

Effective Health Education and Risk Reduction program activities:

- State realistic, specific, measurable, and attainable program goals and objectives.
- Identify methods and activities to achieve specific goals and objectives.
- Define staff roles, duties, and responsibilities.
- Define the populations to be served by geographic locale, risk behavior(s), gender, sexual orientation, and race/ethnicity.
- Assure that educational materials and messages are relevant, culturally competent, and language- and age-appropriate.
- Include professional development for all program staff.
- Include a written policy and personnel procedures that address stress and burnout.
- Include written procedures for the referral and tracking of clients to appropriate services outside of the agency.
- Provide for collaboration with other local service providers to assure access to services for clients.
- Assure confidentiality of persons served.

Effective Health Education and Risk Reduction evaluation activities:

- Include process evaluation. (See Appendices.)
- Require consistent and accurate data collection procedures, including number of persons served, quantity and type of literature or materials distributed, and demographics of persons served. A description of the tools to be used and definitions of various measurements (e.g., "unit of service" and "contact") should be outlined.
- Include staff supervision, observation, evaluation, and feedback on a regular basis. (See Appendices B-D.)
- Include feedback from persons served.
- Designate staff who are responsible for evaluation and quality assurance activities, for compiling and analyzing data, and for documenting and reviewing findings.
- Define methods for assessing progress toward stated process goals/outcome objectives.
- Include mechanisms for measuring the use of referral services.
- Provide findings for program modifications.

Core Training for Health Education and Risk Reduction Activities

Staff training is an important element in the development of a sound program. The suggested areas in which health education and risk reduction staff should receive training are listed below. Not all staff members should receive training in all the listed areas. The outlined training areas provide various program and management staff with the specific technical support necessary to implement their component of the health education and risk reduction program.

Effective training plans for Health Education and Risk Reduction

- Provide basic HIV, STD, and tuberculosis (TB) health education information.
- Provide bleach use instruction.
- Increase knowledge of substance use/abuse.
- Provide orientation to human sexuality, including diverse lifestyles and sex practices.
- Enhance sensitivity to issues for persons living with HIV/AIDS and STDs.
- Recognize cultural diversity and enhance cultural competence.
- Provide an orientation to the agency, community, and available community resources.
- Include ongoing professional development for staff.
- Provide opportunities for role play, observation, and feedback, including the use of video replay where possible.
- Provide training in the dynamics of community and agency collaboration.
- Enhance basic health education concepts.
- Provide orientation to community resources.
- Identify additional sources for updated information.
- Build communication skills (e.g., active and reflective listening, clear speaking).
- Provide for regular updates on analyses and programmatic interpretations of data.
- Provide training on program planning, operations, and supervision.
- Provide orientation to safer sex guidelines.
- Provide training on developing HIV/AIDS publications and resources.
- Enhance basic knowledge of family planning and contraception.
- Increase knowledge of treatment and therapy for people living with HIV and AIDS.
- Provide training on crisis intervention.
- Provide training on street and community outreach.
- Provide ongoing discussion on grief and bereavement.
- Provide training on confidentiality and privacy.

Community Needs Assessment

The HIV prevention community planning process requires an assessment of HIV prevention needs based on a variety of sources and different assessment strategies. This assessment serves as the basis for the development of a comprehensive HIV prevention plan. In addition, more targeted needs assessment may be needed for effective health education program planning for health departments and non-governmental

organizations (NGOs). Tailored needs assessments enable the program planner to make informed decisions about the adequacy, availability, and effectiveness of specific services that are available to the target audience.

For the purposes of developing specific health education and risk reduction activities, a targeted needs assessment assists in the following:

- Establishing appropriate goals, objectives, and activities.
- Defining purpose and scope.
- Identifying social/behavioral attitudes, behaviors, and perceptions of the target community.
- Providing the basis for evaluation as part of formative and summative studies of interventions.
- Establishing community-based support for the proposed activities.

The needs assessment may be informal or formal. An informal needs assessment may occur through frequent conversations and personal interactions with colleagues and clients. Staff and clientele interact with each other when services are being delivered; therefore, clients may inform them about services they find useful or unsatisfactory. Also, staff meetings are a vehicle for sharing and transferring information among colleagues. Through both of these processes, staff can usually determine whether there are gaps in services.

A formal needs assessment involves a systematic collection and analysis of data about the client population. This process may uncover needs that may not be identified through an informal process.

A formal needs assessment requires the program planner to do the following:

- Identify questions that need to be answered.
- Determine how the information will be collected and from whom.
- Identify existing sources of data, e.g., needs assessment data from the HIV prevention community planning group.
- Collect the data.
- Conduct a comprehensive analysis of the data.

The program staff should review data from the HIV prevention community planning needs assessment to determine what additional information is needed. A variety of information would be useful in developing program activities, including the following:

- Socioeconomic and demographic status of the overall community and the specific populations being targeted.
- Current statistics and trends involving HIV/STD disease.
- Existing gaps in HIV/STD programs and services.
- Social indicator data to examine significant and relevant factors that influence prevalence of HIV/STD disease, e.g., substance abuse, teenage pregnancy.
- Identification of other programs and resources that focus on the same target audience.

Before conducting a needs assessment, program staff should consult with community leaders from the client or target populations. This is important in order to determine the leaders' perceptions of their communities' needs, to discuss the agency's plan for conducting the assessment, and to begin to cultivate a working relationship with the leaders in order to attain community support for the proposed activities.

How to Conduct a Needs Assessment

- Identify sources of information and data.
- Review existing literature on the specific problem.

- Survey other agencies/organizations in the community to avoid unnecessary overlap in program activities and to identify emerging issues and new resources.
- Interview key informants and community members who have knowledge of or experience with the problem.
- Consult with national/state agencies where specific data, literature, or experience are deficient.

How Needs Assessments Affect Program Evaluation

A needs assessment is a component of program evaluation. Each element of a needs assessment plays a significant role in the planning, implementation, and management of effective education programs. If a program is to be evaluated, the degree to which the program addresses the needs of the target audiences must be examined.

Both qualitative and quantitative methods of data collection and evaluation are useful. Qualitative methods afford the target audiences an opportunity to express their thoughts, feelings, ideals, and beliefs. Examples of qualitative methods include informal interviews, focus groups, and public forums. These methods are designed to assist the program staff in identifying problems or gaps that the agency may not have recognized, e.g., barriers to service delivery and client dissatisfaction.

Quantitative methods render statistical information. Examples include questionnaires and surveys, results of studies of the client populations' attitudes and beliefs about HIV/STD disease, and information derived from program activities, e.g., number of condoms distributed and documented requests for services.

Note: For further reading on needs assessment, see "Chapter 5: Assessing and Setting Priorities for Community Needs," Handbook for HIV Prevention Community Planning, Academy for Education Development, April 1994.

Collaborations and Partnerships

The HIV prevention community planning process calls for health departments and affected communities to collaboratively identify the HIV prevention priorities in their jurisdictions. However, some members of these affected communities distrust health departments. They may feel that government officials have not traditionally reached out to them until certain health issues have also threatened the greater public health, i.e., the majority community. Sexually transmitted diseases, other communicable diseases, and substance abuse have long been problems in disadvantaged and disenfranchised communities. Injecting drug users (IDUs) were dying of endocarditis, hepatitis B, and drug overdose long before AIDS. For years, the tuberculosis epidemic persisted in poor African American and Hispanic neighborhoods, while prevention and treatment resources dwindled. Consequently, developing collaborative working relationships with affected communities for the purpose of HIV prevention may pose special challenges to many state and local health departments.

In the United States, public health officials frequently underestimate the strengths and resourcefulness of affected communities. As a result, state and local health departments and communities have seldom come together in partnership. In many instances, state and local health departments have not sought the support of, or consulted with, community members before designing and implementing community intervention efforts. At times, public health officials may have inadvertently stigmatized communities in their attempts to intervene and promote public health.

Affected communities are acutely aware of the peculiarities of public health as it relates to them. Some have asked, "Is this a war on drugs or on us" Despite government support for community-base and HIV prevention community planning, many communities remain wary of public health programs as they have been implemented by officials in their communities.

As if this lack of confidence were not challenging enough to state and local health departments, many communities genuinely suspect conspiracy when health officials implement programs for them. Many disadvantaged, disenfranchised persons not only distrust the government, but they may also fear it. For African Americans, the Tuskegee Study continues to cast its own specter of doubt as to whether or not public health officials are truly committed to ensuring the public's health. Hispanic farm workers continue to struggle with government pesticide regulators who seem indifferent to the dangers that farm workers face in the workplace. For Native Americans living on reservations, the quality of health is chronically poor, and life expectancy is diminished. Within many communities, there is a pervasive belief that the government "does not care," or worse, that it "will experiment on them."

Although the AIDS epidemic has illustrated the real value of developing partnerships among local and state health departments and communities, achieving communication, collaboration, and cooperation with these communities and maintaining the relationships in a climate of distrust, apathy, and even fear is daunting. Such a task will surely require cultural sensitivity, competency, respect, and the most critical of all elements, time.

In particular, for an effective HIV prevention community planning process, state and local health departments must develop strong linkages and collaborations with affected communities. A working definition of collaboration is the process by which groups come together, establishing a formal commitment to work together to achieve common goals and objectives. Collaborative relationships are also referred to as coalitions or partnerships. Regardless of the term, the concept is a crucial one.

To facilitate the formation of effective community planning groups and other partnerships, health departments need to understand not only the knowledge and behaviors of their client populations, but also their attitudes toward and beliefs about their own communities, the government, and public health. Health departments will want to assess these same issues among their own employees. In addition to this understanding, to fully achieve cultural competence, to have the capacity and skills to effectively function in environments that are culturally diverse and composed of distinct elements and qualities, health department professionals must also develop a respect for cultural differences. They must appreciate how culture and history affect their clients' perceptions, beliefs, attitudes, and behaviors, as well as their own.

For many health departments and community organizations, responding to the AIDS epidemic means long-term institutional change. Simply channeling HIV resources to affected communities through community-based and national non-go formation of real working relationships among partners who perceive each other as equal. The community planning process addresses these issues by emphasizing the importance of assuring representation, inclusion, and parity in the planning process.

An important program objective for health departments may be to gain acceptance and credibility in the communities they seek to serve. To assume that these will come automatically or even easily may demonstrate cultural insensitivity and incompetence. Respect and regard for the perceptions of those being served will help eliminate barriers to HIV prevention and will build the bridges to better health.

How Can Collaborations Help?

Collaborations can:

- Facilitate strategic planning.
- Help prevent duplication of cost and effort.
- Maximize scarce resources.
- Integrate diverse perspectives to create a better appreciation and understanding of the community.
- Provide comprehensive services based on the client's needs.
- Increase client accessibility to health services.

- Improve communication between the health department and its constituents.
- Provide liaison for clients unwilling to seek services from government organizations.

At the same time, public health agencies must be aware of some of the difficulties inherent in collaborative relationships:

- Organizations and individuals may have hidden agendas.
- Intra-agency trust may be difficult to develop.
- Decision-making processes may become complicated.
- Organizations have to collectively take the responsibility for program objectives, methods, and outcomes.
- The group may lack a clear sense of leadership and direction.
- The group may lack a clear sense of its tasks and responsibilities.

What Influences the Success of a Collaborative Effort?

Many factors influence the success of a collaborative effort; however, the following factors are vital:

- The group must develop a sense of mutual respect, trust, purpose, and understanding.
- There must be an appropriate representation of groups from all segments of the community for whom the activities will have an impact.
- All members must "buy into" and develop ownership in the development and outcome of the process.
- Effective communication among members must be constant and ongoing.
- The group must position itself as a leader in the community, eager to work with persons from all communities in developing effective prevention strategies.
- The group must be willing to try non-traditional strategies.

The development and maintenance of collaborative relationships are challenging and rewarding tasks. Collaborations can make positive, significant changes in communities, if they are developed in a way that is culturally competent and respectful of the people for whom interventions will be developed. Health departments must also consider whether efforts are cost-efficient, appropriate, duplicative, and accessible; they must determine where community-based organizations fit into the overall realm of prevention activities. Collaborations should be structured with long-term results in mind. They should serve as a bridge to better relations between state and local health departments and the community, ultimately effecting better health in the community.

Individual-Level Interventions (ILI)

Individual-level interventions (ILI) consist of health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. An example of ILI is individual prevention counseling.

Individual Prevention Counseling

The purpose of individual prevention counseling is to provide one-time counseling and health education interventions to persons who are at high risk for HIV infection, to promote and reinforce safe behavior. This type of counseling -- which is not linked with HIV antibody testing -- provides education and counseling at sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers, social service offices, or medical clinics. Individual prevention counseling may be delivered by peers or non-peers.

Guidance and Standards for Individual Prevention Counseling

INTRODUCTION

The purpose of Individual Prevention Counseling (IPC) is to provide personalized counseling and health education interventions to persons who are at high risk for HIV infection, to promote and reinforce safe behavior. This type of counseling is not linked with HIV antibody testing, although it is similar to pre-test counseling.

It can be a one-time intervention, or the client and counselor can meet multiple times. The intervention creates the opportunity for an individual to learn to recognize her/his own risk, ask questions about safer sex in a safe environment, and formulate personal risk reduction plans.

IPC also involves building skills to change the behaviors that put one at risk for HIV and providing support for maintaining a low risk status. Counselors assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Counselors also provide referrals and information in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.

Individual Prevention Counseling provides education and counseling at sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers, community-based organizations, or medical clinics. But is also provided to participants in other prevention interventions who demonstrate the need for individualized intervention but do require a more intense intervention like prevention case management. IPC is also a highly mobile intervention that can take place in an outreach activity.

These interventions also facilitate linkages to services in both clinic and community settings

This guidance is based on the CDC guidance for Counseling and Testing and on the CDC guidance for Prevention Case Management. The two levels of recommendations this document provides are as follows:

Standards: Specific standards are provided in several sections. These standards should be applied consistently to the delivery of individual prevention counseling services. They must be followed in virtually all cases.

Guidance: The main text of this document provides overall program guidance in developing, implementing, and evaluating Individual Prevention Counseling programs. The overall guidance is intended to be more flexible and should be followed in most cases. The overall guidance can and should be tailored to fit individual program needs.

Goals of Individual Prevention Counseling (IPC)

The goals of an IPC program are as follows:

- To provide individualized HIV risk-reduction counseling to help initiate and maintain behavior change to prevent the transmission or acquisition of HIV;
- To facilitate referral services, as needed, for clients' medical and psychosocial needs that affect their health and ability to change HIV-related risk-taking behavior; and
- To provide information and referrals, as needed, for HIV secondary prevention needs of persons living with HIV or acquired immunodeficiency syndrome (AIDS).

Necessary Elements of IPC

- **Prevention Counseling:** Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. It also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate behavioral risk.
- **Provision of Referrals:** Clients may require referral for physical and psychological evaluations, appropriate therapies (i.e., drug treatment), and support services to enhance or sustain risk reduction behaviors. Each program should maintain complete knowledge of referral resources, including the availability, accessibility, and eligibility criteria for services.

Standards for Service Provision

Required

- According to the Units of Service document developed by the SFDPH HIV Prevention Section, counseling sessions must be at least 30 minutes long and must include:
  1) HIV/STD information and dissemination;
  2) documentation of discussion of risk behaviors;
  3) counseling;
  4) skills building;
  5) documented referral(s), if given; and
  6) documentation of client demographics.
- Counseling must be client-centered and focus on the needs of the individual.
- Counseling should acknowledge substance use, housing issues, joblessness, etc. as possible barriers to HIV prevention; and should provide linkages to services for housing, substance treatment, jobs, etc.
- Counselors should be able to demonstrate that they understand how the target population is affected by other (non-HIV-specific) issues, and should address those issues to some degree, whether by referrals or otherwise.
- Staff in clinic or other health care settings are given adequate training in client-centered counseling.
- Staff/volunteers should be trained in issues relevant to adolescents.

Recommended

- Peer models can be very effective in delivery of IPC.

Guidelines for Providers

Risk Assessment Development

Agencies should provide prevention counseling tailored to individual client needs and should develop an effective method to involve clients in identifying their risk behaviors. This approach should also address local and specific circumstances that might influence the client's perception of risk.

Standards

HIV prevention program managers must make certain that the following are achieved:

- Provision of training and quality assurance to ensure that staff has the adequate skills to (1) identify and assess risk behavior of all clients counseled, and (2) to make appropriate referrals when necessary;
- Determination of appropriate site-specific strategies, approaches and tools for risk assessment of clients, based on demographic and risk profiles;
- Procedures to maximize targeting of clients for prevention counseling based on risk profiles.

Referral Service Development

A thorough client assessment often indicates a need for services that cannot be provided by the counselor (e.g. drug treatment, peer support groups, etc.). To ensure that clients receive appropriate care, the program must establish a procedure for referring persons to sites that provide services in a timely, efficient, and professional manner. A collaborative relationship should have already been established with the appropriate representative of the referral site. Program managers should routinely conduct site visits to referral sites as a quality assurance measure to ensure that settings and services are appropriate to client needs.

Program managers should maintain a current list of community and institutional referral resources such as HIV prevention programs, mental health services, infectious disease specialists and clinics, free clinics, social service agencies, emergency medical services, hospitals, prenatal care clinics, family planning clinics, AIDS service organizations, HIV/AIDS community-based organizations (CBOs), substance abuse treatment facilities, and religious institutions.

Counseling should acknowledge substance use, housing issues, joblessness, etc., as possible barriers to HIV prevention; and should provide linkages to services for housing, substance treatment, jobs, etc.

Special Considerations

Some clients may be in need of prevention case management services (PCM), a highly individualized and intensive HIV risk-reduction strategy. PCM is intended for persons at greatest risk of transmitting or acquiring HIV whose needs are not being effectively served and whose behavior is not influenced by less intensive HIV prevention interventions, such as street outreach, group-level strategies, or individual prevention counseling.

Characteristics of PCM differentiate it from other prevention activities. PCM characteristics include the following:

- The formal enrollment of "clients" into an on-going service guided by professional standards.
- The development of a formal relationship between a prevention case manager and a client, a relationship that is characterized by active, cooperative prevention planning, problem solving, counseling, and referral provision.
- In-depth, on-going, risk-reduction counseling that addresses specified behavioral objectives.

- The need for professional staff skills to conduct most functions of PCM, including assessment, prevention planning, and risk-reduction counseling.

Some clients may require more than one session of IPC, which is not as intensive or comprehensive as PCM. Program managers should develop agency protocols for the provision of referrals to other IPC sessions (i.e. multi-sessions of IPC), given the risk profiles of the target populations served.

Standards

HIV prevention program managers must develop a process for routine referral that includes the following:

- A written referral process for identifying, evaluating, and updating referral sources in the site's operations manual;
- A mechanism to provide clients with immediate access to emergency psychological or medical service;
- Appropriate referral resources for;
    1. Any client at-risk for HIV infection who may be in need of support to maintain safer behaviors,
    2. Clients who continue to engage in risk behavior,
    3. HIV positive persons who need a medical assessment.

Client Recruitment

Individuals in need of individual prevention counseling are often identified during group-level interventions, such as psycho-educational skills building groups. Facilitators of these activities should offer their services for this intervention, which could be provided at the end of the group session or at another time agreed to with the client.

Making an IPC program well-known and visible for those persons the program intends to serve is important. Recruitment strategies might include:

(1) Training outreach workers and group facilitators to identify individuals in need of counseling and make referrals to the service;
(2) Recruiting clients from other programs such as an STD clinic, a women's health clinic, or a drug treatment program.
(3) Training outreach workers and group facilitators to identify individuals in need of counseling and make referrals to the service;
(4) Developing materials advertising this service and making them available at all prevention activities.
(5) Recruiting clients from other programs such as STD clinics, health clinics or a drug treatment programs.

Educational and Risk Reduction Materials

Culturally competent, linguistically specific, and developmentally appropriate written HIV information must be available to clients. Current written materials should be prominently displayed in public areas and made available to clients.

In addition, condoms and other risk reduction materials should be available to the client—directly from providers and easily accessible without the client having to ask.

Guidelines for Counselors

Risk Assessment

Risk assessment – an integral component of HIV prevention counseling – is based on the premise that certain behaviors increase risk for infection with HIV. The counselor should engage the client in a discussion that enables the client to recognize risk for HIV. Because the risk-assessment process serves as the basis for assisting the client in formulating a plan to reduce risk, it is an essential component of all counseling. The approach should be client-centered, with the counselor assisting the client in recognizing and understanding their HIV-risk.

When the counselor assesses a client's risk, the approach should be thorough and individualized for each client. The counselor should accept that the client's disclosures concerning risk behaviors correspond to his or her readiness to initiate behavior change. Each counselor should develop effective interactive methods to involve the client in identifying risk behaviors and initiating risk reduction measures. Counselors should understand how the target population is affected by other (non-HIV-specific) issues, and should address those issues to some degree, whether by referrals or otherwise.

Standards

Determine the client's prevention and clinical needs by engaging him/her in a discussion that addresses: client's reason for participating in the session and other relevant concerns; client's resources and support systems; behavioral and other sources of risk, demographic and epidemiologic factors that influence risk; client awareness of risk; readiness to change behavior; and receptiveness to available services and referrals.

Listen for and address, as appropriate, information such as the following:

- Number of sex partners (casual and steady) and sexual activities including vaginal, anal, and oral sex, both receptive and insertive activities;
- Sex in exchange for drugs, money, or other inducements;
- Use of substances such as alcohol, cocaine, etc., in connection with sexual activity; and
- Condom use and other "safer-sex" methods utilized by the client.

Individual Prevention Counseling

Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate the risk. Prevention counseling should also:

1) facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial;
2) translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status; and
3) help clients initiate and sustain behavior changes that reduce their risk of acquiring or transmitting HIV.

Standards

Provide client-centered counseling to:

- Establish and/or improve the client's understanding of his/her HIV risk;
- Assess the client's readiness to adopt safer behaviors by identifying behavior changes the client has already implemented; and
- Involve the client in an assessment to determine which of his or her behaviors may result in a risk of acquiring HIV infection.
- Tailor the counseling session to the behaviors, circumstances, and special needs of the client.
- Assist the client in recognizing those behaviors which put him or her at risk for HIV.
- Identify steps already taken by the client to reduce risk and provide positive reinforcement.
- Identify barriers/obstacles to the client's previous efforts to reduce risk.
- Determine one or two behavioral changes the client may be willing to make to reduce risk.
- Discuss the steps necessary to implement these changes.
- Address any difficulties the client anticipates in taking these steps.
- Respond to the client's concerns.

SPECIAL CONSIDERATIONS

As part of the assessment, the counselor should ascertain the client's understanding of HIV transmission. When appropriate and relevant to the client, the counselor may review risk reduction options with the client, for example:

- Abstain from sex and injecting street drugs; enroll in a drug treatment program.
- Practice mutual monogamy between two HIV negative persons.

- Use condoms and other barriers to prevent STDs and HIV transmission.
- Modify sexual practices to low or no risk behaviors.
- Limit the number of sex partners.
- Disinfect drug-injecting equipment and avoid sharing paraphernalia.
- Discuss related healthy behaviors, such as limiting the use of alcohol and other drugs.

CDC Guidelines for Risk Reduction Counseling

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

The purpose of risk reduction counseling is to provide counseling and health education interventions to persons who are at high risk for HIV infection. The interventions promote and reinforce safe behavior. The participants may range from a single individual to couples, families, groups, or entire communities.

Risk reduction counseling is interactive. Such counseling assists clients in building the skills and abilities to implement behavior change. These programs offer training in the interpersonal skills needed to negotiate and sustain appropriate behavior changes. For example, sessions could concentrate on delaying the initiation of sexual activity, on methods for avoiding unsafe sex and negotiating safer sex, and on techniques to avoid sharing injecting drug paraphernalia. Risk reduction may be implemented in a variety of formats. The interventions may take the form of role plays, safer sex games, small group discussion, individual counseling, or group counseling.

Effective risk reduction counseling sessions:

- Emphasize confidentiality.
- Begin with an assessment of the specific HIV/STD prevention needs of the client(s).
- Identify, with the group or individual, the appropriate goals/ objectives (e.g., condom use negotiation skills for female sex partners of IDUs).
- Use skills-building exercises designed to meet the specific needs of the client(s).
- Include negotiations with the client(s) on suggestions and recommendations for changing and sustaining behavior change as appropriate to their situation.
- Enable/motivate participants to initiate/maintain behavior change independently.
- Enhance abilities of the participant(s) to access appropriate services (e.g., referrals to drug treatment).

Risk Reduction Program Plans

An effective risk reduction program plan includes the following:

- Protocols and procedures specific to each activity and logistical check lists for implementation.
- Development of innovative behavior modification strategies.
- Provision for regular updates in techniques for skills building.
- Provisions for updates on client-focused approaches to risk reduction activities.
- Provision for updates in techniques for increasing facilitators' skills in managing group or one-on-one dynamics.

Group-Level Interventions (GLI)

Group-level Interventions (GLIs) consist of health education and risk-reduction counseling that shift the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide-range of skills, information, education, and support.

Some providers may consider general education activities to be group-level interventions. However, for the purposes of CDC reporting, GLI does *not* include "one-shot" educational presentations or lectures that lack a skills component.

Interventions that focus on groups as a target for HIV prevention and education may be structured to encourage the initiation and maintenance of safer behaviors, to provide interpersonal skills training, and/or to sustain appropriate behavior change. As with individual counseling, the intervention may be delivered by a peer or a non-peer. Programs usually include information about condom use, negotiation of safer sexual behaviors and risk-reduction strategies for IDUs. Unlike CTRPN and individual interventions, group interventions may target those at low risk for HIV/AIDS as well as those at high risk. An example of group-level interventions is psycho-educational skills-building groups.

Standards for Psycho-Educational Skills-Building Groups

Psycho-Educational Skills-Building Groups are based on the Health Belief Model – which identifies the key elements of decision making, such as the person's perception of susceptibility, perceived severity of the illness, and the perceived barriers to prevention – and on Social Cognitive Theory – which views learning as a social process influenced by interactions with other people.

Individuals participate in multiple-session group workshops. They attend anywhere from 4 to 12 sessions – for a total of 12 to 24 hours – that are designed to increase their ability to initiate and sustain safer-sex, risk-reduction and healthy behaviors. Workshop topics usually build on each other from session to session. Multiple sessions provide an opportunity to go into greater depth about HIV risk reduction issues and strategies, providing an enhanced opportunity for behavior change.

Psycho-educational skills-building programs include the following essential components:

- Interventions are conducted at locations and times that are convenient and safe for the target population.
- Sessions are facilitated by a trained facilitator or professional in a manner that is culturally and linguistically appropriate for the target population.
- Workshops provide the opportunity for confidential, one-on-one interactions with the provider before or after the intervention (individual level counseling).
- The format includes hands-on activities, such as role-playing.
- The sessions incorporate practical, useful skills-building exercises or demonstrations based on the needs of the target population.
- Topics or issues covered in the workshops sessions include information and education on risk and harm reduction; self-risk; self-esteem; self-efficacy; communication and negotiation skills; problem and conflict resolution; substance abuse; peer pressure; cultural norms such as religious beliefs and family values; and gender identity and sexual orientation.

- The interventions address psycho-cultural issues that are not necessarily related to HIV but may prevent members of the target population from engaging in safer sex and other healthy behavior consistently. This includes co-factors such as a history of sexual, physical and mental abuse; poverty, homelessness, unemployment, lack of social support, mental health stressors and lack of access to prevention resources due to lack of knowledge of services, language or literacy.
- The program continually identifies additional issues and community needs to be addressed.
- Facilitators and other staff provide referrals to other prevention services, including counseling and testing, prevention case management, substance abuse treatment and early intervention.

Other Considerations

Multiple session group workshops should provide incentives for participants that are appropriate to the workshops and the target population, especially for hard-to-reach groups. Providers can encounter difficulty in trying to recruit or retain participants for continuing groups and may require a “hook” other than HIV prevention to motivate regular attendance, particularly for youth participants.

The effectiveness of time-limited psycho-educational skills-building groups can be enhanced if participants are linked to follow-up support groups (peer and non-peer-led) to help participants maintain healthy behavior.

Counselors should follow-up with participants to evaluate the adoption or maintenance of safer behaviors.

Using Support Groups for HIV Prevention

From the CDC “Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Groups can provide significant informational and therapeutic HIV risk reduction interventions to individuals who are ready to initiate and/or maintain specific health promoting behaviors. Groups are usually formed around common issues or problems. Some groups, originally established to provide information and skills training, may evolve into support groups, which encourage maintenance of newly acquired behaviors. Utilizing groups suggests a systems approach to intervention. Groups provide access to social networks that enable and reinforce health enhancing behavior change through peer modeling and peer support.

Although open-ended groups (e.g., support groups) may have less structure than the more close-ended kinds of groups (e.g., educational or skills-building), both types should have clearly defined goals/objectives and specifically defined processes. The structure of a group should be determined based upon the needs of the members.

At times, the open-ended group with its open enrollment and extended life is more suited to members' needs. By being open-ended, potential members are able to drop in when they need to and thus avoid the wait for new groups to form. This type of group is likely to appeal to the individual whose commitment to the group's process is initially limited. In the open-ended group, members determine their own topic of discussion at each meeting. For this reason, an open-ended model, that encourages drop-ins, is perhaps less amenable to instructional sessions which usually need to build on information presented at earlier meetings. The open model, because of its unpredictable structure and enrollment, may be more amenable to process evaluation (i.e., percentage of agency's clients attending a determined number of sessions).

The close-ended model will have a defined lifespan and is also likely to set membership limits. The closed group allows for important continuity and facilitating the development of trust among members, as they get to know each other over time. Members can expect the same individuals to be present each week,

which can aid in building significant, supportive relationships. The closed group model is more suitable to the establishment of client-specific outcome objectives that can be monitored over time (i.e., self-reported reduction in number of sex partners at the end of 8 weeks of group attendance).

There are significant advantages to both open and closed models, and determination of which model to employ is based on the needs of an agency's clients and on an agency's capacity to implement the model. Whatever the model selected, the size of the group is an important consideration. Group facilitation is not crowd control. Smaller groups can be more manageable and result in enhanced group dynamics.

Group facilitators or instructors may be peers or professionals; in some instances, they may be both. They should be skilled at promoting effective group dynamics, encouraging reticent members to speak up and guiding the dominant ones. Skilled facilitators and instructors are astute observers. They not only listen to what is being said, but they also note nonverbal cues. Good observation skills are especially critical for support or therapeutic group facilitators. Skilled facilitators and instructors are able to see changes in body language, hear sighs, and catch subtle changes in facial expressions.

Groups are a naturally occurring phenomenon. People come together for a variety of reasons and left to themselves, they will develop informal but powerful supportive networks. Proactive HIV risk reduction programs can tap into this resource and enhance program effectiveness.

Outreach

Outreach interventions are generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate (e.g. bars, parks, shooting galleries). Outreach usually includes distribution of condoms, barriers, bleach and educational materials. Includes peer opinion leader models.

Street outreach programs aim to encounter clients in their own community who are unlikely to be receiving important HIV prevention services. This strategy usually targets individuals at informal sites where persons engaged in high-risk activities congregate and includes the distribution of condoms, bleaching kits and literature. Outreach workers -- who may be trained peers or non-peers -- also provide referrals to prevention, substance abuse or early intervention programs.

Standards

Agencies that provide street and community outreach will frequently engage peer educators to conduct intervention activities. This method provides an opportunity for individuals to perceive themselves as empowered by helping persons in their communities and social networks, thus supporting their own health enhancing practices. Street outreach programs include the following essential components:

- Face-to-face outreach interventions in community settings at appropriate times of the day/night, week and year;
- Education on HIV transmission and on substance abuse/harm reduction that is provided in face-to-face interactions and promote the client's current prevention needs, whether these are for no interaction, prevention materials only, basic information, referrals to or on-the-spot case management, or counseling on HIV test results;
- Distribution of male and female condoms and barriers, bleaching kits, and culturally and linguistically appropriate written information on the correct use of condoms and bleaching kits;
- Distribution of culturally and linguistically appropriate literature on HIV prevention and substance abuse/harm reduction;
- Referrals to prevention, substance abuse or early intervention programs, as well as to services that can provide support in maintaining the client's seronegative status, such as:

    Mental health services

    Housing and shelter services

    Support groups for HIV-negative individuals

- Establishing the educators and the agency they represent as resources for the community regarding HIV, STDs, substance abuse and support for other issues (such as homophobia and discrimination based on gender identity).

CDC Guidelines on Outreach

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Street outreach commonly involves outreach specialists moving throughout a particular neighborhood or community to deliver risk reduction information and materials. The outreach specialist may set up an HIV/AIDS information table on a street corner. They may supply bleach to injecting drug users at shooting galleries and condoms to commercial sex workers and their customers at the hotels or locations that they frequent. The fundamental principle of street outreach is that the outreach specialist establishes face-to-face contact with the client to provide HIV/AIDS risk reduction information and services.

Effective street outreach staff:

- Know the target group's language.
- Have basic training and experience in health education.
- Are sensitive to community norms, values, cultural beliefs, and traditions.
- Have a shared identity with the population served, stemming from shared common personal experiences with the group.
- Are trusted by the group they serve.
- Act as role models to the clients they serve.
- Advocate for the population served.
- Act as liaisons between the community and the agency.
- Are informed about community resources and use them.

Street outreach is not simply moving standard agency operations out onto the sidewalk. A number of specific issues are unique to the delivery of services through this type of outreach and must be considered before instituting a program of street outreach. These matters are usually addressed in an agency's street outreach program plan and include the following:

- Regular contact among educators, outreach specialists, and supervisors.
- Observation of potential outreach areas to determine the locations, times of day, and the day of the week that are most productive for reaching the population to be served.
- A written and comprehensive field safety protocol that is regularly updated.
- Establishment of and adherence to regular and consistent schedules of activities, including times and locations.
- A mechanism for measuring the use of referral services.
- Creation and maintenance of a positive relationship between the agency and the local law enforcement authorities.
- Identification and development of collaborative relationships with gatekeepers (key informants) in the community.
- Activities for building and earning the trust and respect of the community.
- Descriptions of skills-building exercises relevant to stated program objectives.
- Establishment of mechanisms for maintaining client confidentiality.

Using Peers in HIV Prevention Interventions

While any intervention can be delivered either by a non-peer professional or by a trained peer, available data suggest that peer-based interventions are superior for achieving behavior change.

Peer education should not be seen as an intervention in itself but as a major component of individual, group and community level interventions, such as street outreach. It involves providing

prevention services by individuals who are recruited from the target population and trained in HIV, substance abuse, peer counseling and outreach.

Peer education is based on the diffusion of innovation theory, which suggests that people are more likely to adopt new behaviors if they receive information from someone that is similar to them and is perceived as a role model. Programs using peer education should include the following elements:

1. Training, counseling and supervision of peer educators.
2. Safety protocols and support structures for the educators.
3. An agreement detailing the responsibilities of peer educators.
4. Peer education programs should also provide:
    - Incentives or compensation for the peer educators.
    - A mechanism to incorporate feedback and the experiences of the peers into program development.
    - A mechanism to insure diversity among the peer educators.

CDC Guidelines for Programs Using Peer Educators

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Agencies that provide street and community outreach will frequently engage peer educators to conduct intervention activities. Peer education implies a role-model method of education in which trained, self-identified members of the client population provide HIV/AIDS education to their behavioral peers. This method provides an opportunity for individuals to perceive themselves as empowered by helping persons in their communities and social networks, thus supporting their own health enhancing practices. At the same time, the use of peer educators sustains intervention efforts in the community long after the professional service providers are gone.

Effective peer educators:

- Have a shared identity with the targeted community or group.
- Are within the same age range as the targeted community or group.
- Speak the same "language" as the community or group.
- Are familiar with the group's cultural nuances and are able to convey these norms and values to the agency.
- Act as an advocate, serving as a liaison between the agency and the targeted community or group.

Peer education can be very powerful, if it is applied appropriately. The peer educator not only teaches a desired risk reduction practice but s/he also models it. Peer educators demonstrate behaviors that can influence the community norms in order to promote HIV/AIDS risk reduction within their networks. They are better able to inspire and encourage their peers to adopt health seeking behaviors because they are able to share common weaknesses, strengths, and experiences.

Agencies often recruit and train peer educators from among their client populations. However, not everyone is an educator. The model client does not necessarily make the model teacher, no matter how consistently s/he practices HIV/AIDS risk reduction or is liked by agency staff. Peer educators should be instinctive communicators. They should be empathetic and non-judgmental. They should also be committed to client confidentiality.

Peer educators will not replace an agency's professional health educators, but they can complement the intervention team and enhance intervention efforts. Peer educators may act as support group leaders or street outreach volunteers who distribute materials to friends. They may be members of an agency's speaker's bureau and give workshop presentations.

They may run shooting galleries, keeping bleach and clean water readily available to other (IDUs). They may be at-risk adolescents who model responsible sexual behaviors. The role of the peer educator is determined by the intervention need of the client population and the skill of the peer educator.

Although some agencies will hire peer educators as paid staff, others will not. As in the case of speaker's bureaus, engaging volunteer peer educators also involves issues of volunteer recruitment, training, and retention. Several references in the list of publications included at the end of this document provide more information on this issue. In addition to the core elements identified for health education and risk reduction activities, an effective peer education program plan contains the following:

- A written and comprehensive field safety protocol (see sample below).
- A description of skills building exercises relevant to the stated program objectives.

Sample – Field Safety Protocol for Outreach Workers

Field safety protocols are based on program activities and are intended to provide the staff and peer educators with guidance regarding their professional behavior.

- Carry picture identification (I.D.) at all times that includes name of the organization, name of the project, your name, and the purpose for your presence.
- Work in pairs and always know where your partner is.
- Establish a mechanism to keep your supervisor aware of your location and activities.
- Establish contact with local police precincts in the area. If appropriate for your program, maintain relations with the police; introduce the program and staff.
- Have contingency plans for worst case scenarios and share them with your partner.
- Make sure you have made contact with and have permission from a key person in the community before entering the setting in which you will conduct the intervention (e.g., bars, shooting galleries, crack houses, or local high schools).
- Leave the area if tension or violence is observed or perceived.
- Avoid controversy and debate with clients and program participants.
- Adhere to a schedule for outreach or peer education.
- Avoid drinking alcoholic beverages and buying, receiving, or sampling drugs while conducting outreach or peer education.

Prevention Case Management (PCM)

Prevention Case Management (PCM) is a client-centered HIV prevention intervention with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. It is a one-on-one client service intended to assist both un-infected persons and those living with HIV who are having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and acquisition.

PCM is a hybrid of HIV risk-reduction counseling and traditional case management. It provides an ongoing, sustained relationship with the client in order to assure multiple-session, individualized HIV risk reduction counseling that provides intensive support and referrals to medical, psychological and other services.

The goal of PCM is to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are HIV-positive. PCM is intended for persons who are having or who are likely to have difficulty initiating and sustaining safer behavior.

The **standards** for PCM are included in the following document, the CDC **Guidance** for PCM.

Prevention Case Management - Guidance

Centers for Disease Control & Prevention
National Center for HIV, STD, and TB Prevention
Divisions of HIV/AIDS Prevention
Updated: January 26, 1998

1.0 INTRODUCTION

1.1 HISTORY

This guidance is offered to assist state and local health department human immunodeficiency virus (HIV) prevention cooperative agreement grantees and directly funded community-based organization (CBO) grantees in planning, implementing, and evaluating HIV prevention case management (PCM). The Centers for Disease Control and Prevention (CDC) provides funding for individual-level, health education and risk-reduction activities, which include PCM. Previous guidelines for PCM are published in Guidelines for Health Education and Risk-Reduction Activities, U.S. Department of Health and Human Services, April 1995. This revised guidance supersedes the 1995 PCM guidelines by further detailing essential components and protocols for PCM programs. (A glossary of terms is provided in Appendix A to assist the reader.)

HIV PCM is a client-centered prevention activity, which assists HIV seropositive and seronegative persons in adopting risk-reduction behaviors. PCM is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and acquisition. PCM provides intensive one-on-one prevention counseling and support. In addition, PCM provides assistance in accessing needed medical, psychological, and social services that affect clients' health and ability to change HIV-related risk-taking behavior.

Important issues have emerged from the experiences of those implementing the first PCM programs. As a result of questions about the range of services appropriate for PCM, the type and extent of counseling, and staffing qualifications, CDC staff believes revising programmatic guidance for this activity is important. This guidance provides minimum standards for PCM programs. Individual jurisdictions may develop more specific PCM standards for their own locale that go beyond the minimum standards specified in this document.

These standards and guidance for PCM were established after consultation among experts from HIV prevention programs, academia, and CDC. This revised guidance is also based on a literature review of the existing research (CDC 1997) and a systematic review of PCM programs [Purcell, DeGroff, and Wolitski, Submitted for Publication]. The experiences of organizations implementing PCM over the past three to five years have provided valuable information on which to base this revised guidance. Little outcome evaluation of PCM has been conducted; therefore, CDC bases this guidance, in part, on the review of research of other case management models.

1.2 TENETS OF PCM

This guidance is based on the following tenets and assumptions:

- The fundamental goal of PCM is HIV primary prevention - preventing the transmission or acquisition of HIV.
- Early identification of HIV infection enables individuals to make informed decisions about their own health.
- The primary goals in working with clients are self-determination and self-sufficiency

- High standards for PCM will improve the outcomes for clients.
- PCM is guided by the same broadly accepted professional standards adhered to by other human service professionals such as social workers, counselors, and clinical psychologists.

1.3 STANDARDS AND GUIDANCE

The standards and guidance in this document describe the core elements that are essential for success in planning, implementing, and evaluating a PCM program. They are provided to assist program planners in enhancing their PCM programs and state and local health department personnel who are funding PCM programs. Agencies receiving CDC funds to support PCM program(s) should follow the standards and guidance contained within this document. Agency staff interested in diverting from this guidance should first seek the advice of their state or local health department or CDC project officer. Organizations using funds other than CDC monies to support PCM activities should consider using this document as a guide.

The two levels of recommendations this document provides are as follows:

Standards Specific standards are provided in several sections in boxed text.These standards are intended to be consistently applied to the delivery of PCM services. They must be followed in virtually all cases. Appendix B provides a comprehensive listing of all PCM standards.

Guidance The main text of this document provides overall program guidance in developing, implementing, and evaluating PCM programs. The overall guidance is intended to be more flexible and should be followed in most cases. CDC recognizes that, depending on the client population, setting, and other factors, the overall guidance can and should be tailored to fit individual program needs.

1.4 GOALS OF PCM

The goals of a PCM program are as follows:

- To provide specialized assistance to persons with multiple and complex HIV risk-reduction needs;
- To provide individualized, multiple-session HIV risk-reduction counseling to help initiate and maintain behavior change to prevent the transmission or acquisition of HIV;
- To assess risks of other sexually transmitted diseases (STDs) and ensure appropriate diagnosis and adequate treatment;
- To facilitate referral services for clients' medical and psychosocial needs that affect their health and ability to change HIV-related risk-taking behavior; and
- To provide information and referrals for HIV secondary prevention needs of persons living with HIV or acquired immunodeficiency syndrome (AIDS).

2.0 DEFINING PCM

2.1 WORKING DEFINITION OF PCM

PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is intended for persons having or likely to have difficulty initiating or sustaining

practices that reduce or prevent HIV acquisition, transmission, or reinfection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors.

Priority for PCM services should be given to HIV seropositive persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and reinfection. For HIV seropositive persons, PCM involves the coordination of primary and secondary prevention interventions in close collaboration with Ryan White CARE Act case management providers (See Appendix C for fact sheet on Ryan White CARE Act). Further, PCM ensures the provision of other medical and psychosocial services affecting risk behavior, including STD and substance abuse treatment services.

HIV seronegative persons, or those of unknown HIV serostatus - either (1) engaging in high-risk behavior within communities with moderate to high seroprevalence rates of HIV infection or (2) otherwise at heightened risk of infection - may also be appropriate for PCM.

PCM includes the following seven essential components (See Section 4.2 for further details):

1. Client recruitment and engagement;
2. Screening and assessment (comprehensive assessment of HIV and STD risks, medical and psychosocial service needs - including STD evaluation and treatment, and substance abuse treatment);
3. Development of a client-centered "Prevention Plan;"
4. Multiple-session HIV risk-reduction counseling;
5. Active coordination of services with follow-up;
6. Monitoring and reassessment of clients' needs, risks, and progress; and
7. Discharge from PCM upon attainment and maintenance of risk-reduction goals.

2.2 DIFFERENTIATING PCM FROM OTHER HIV RISK-REDUCTION ACTIVITIES

PCM is conceptualized as a highly individualized and intensive HIV risk-reduction strategy. PCM is intended for persons at greatest risk of transmitting or acquiring HIV whose needs are not being effectively served and whose behavior is not influenced by less intensive HIV prevention interventions, such as street outreach, group-level strategies, or HIV counseling and testing. PCM is considered an individual-level HIV prevention activity and does not typically include group or community-level strategies. Characteristics of PCM differentiate it from these other prevention activities. PCM characteristics include the following:

- The formal enrollment of "clients" into an on-going service guided by professional standards.
- The development of a formal relationship between a prevention case manager and a client, a relationship that is characterized by active, cooperative prevention planning, problem solving, counseling, and referral provision.
- In-depth, on-going, risk-reduction counseling that addresses specified behavioral objectives.
- The need for professional staff skills to conduct most functions of PCM, including assessment, prevention planning, and risk-reduction counseling.

These characteristics of PCM are in contrast to other prevention activities such as street and community outreach and risk-reduction groups in which staff or volunteers, often peers or paraprofessionals, may interact on a brief or limited basis with high-risk individuals. The relationship of PCM to other individual-level HIV prevention activities is illustrated in Figure 1.

Finally, PCM is likely to be more costly than most other HIV prevention activities that employ peers or paraprofessionals to reach larger numbers of people with less time-intensive, staff-intensive risk-reduction strategies (See Section 4.3 for more detail about staff qualifications). However, PCM is likely to be cost beneficial because it emphasizes serving persons with particular difficulty changing behavior and most likely to transmit or acquire HIV.

Figure 1

Street Outreach	**HIV Counseling And Testing**	**Prevention Case Management**
Low Intensity	*Moderate* Intensity	*High* Intensity
Short Duration	*Short* Duration	*Long* Duration
Potential to Reach *High* Number of People	Reaches *Moderate* Number of People	Reaches *Low* Number of People
Low Cost per Person	*Moderate* Cost per Person	*High* Cost per Person
Peers or *Paraprofessional* Staff	*Paraprofessional* or *Professional* Staff	Primarily *Professional* Staff

2.3 DIFFERENTIATING PCM FROM OTHER FORMS OF CASE MANAGEMENT

Case management is widely acknowledged to be an important psychosocial strategy with potential for addressing a wide range of social ills (Rothman 1992). The fundamental principles underlying case management services are that case managers (1) facilitate linking clients to the complex delivery system and (2) help to enable clients, through psychosocial interventions, to benefit from appropriate services. For persons living with HIV and AIDS, case management has emerged as the prominent strategy for coordinating the wide range of needed health care, psychiatric, psychosocial, and practical support services (Mor, Piette, and Fleishman 1989). Although researchers and clinicians have been unable to agree on one widely accepted definition of case management (Baldwin and Woods 1994; Graham and Birchmore-Timney 1990; and Piette, Fleishman, Mor, and Dill 1990), most might agree with the following broad definition of case management:

" . . . The provision for some greater continuity of care through periodic contact between case manager(s) and the client that provides greater (or longer) coordination and brokerage of services than the client could be expected to obtain without case management" (Orwin et al. 1994, p. 154).

Although PCM also provides greater continuity of care, it is specifically focused on HIV-related behavior change. PCM involves the identification of HIV risk behaviors and medical and psychosocial needs that influence HIV risk taking followed by the development of a client-centered Prevention Plan with specific behavioral objectives for HIV risk reduction. Through both direct and facilitative service provision, PCM provides primary and secondary HIV prevention services and facilitates the provision of other medical and psychosocial services affecting risk behavior, including STD evaluation and treatment and substance abuse treatment. HIV primary prevention aims to reduce the transmission and acquisition of HIV infection, whereas HIV secondary prevention aims to prevent a person living with HIV from becoming ill or dying as a result of HIV-related illness and opportunistic infections (Last and Wallace 1992).

The foundation of PCM involves multiple-session risk-reduction counseling in which a variety of strategies are applied by the prevention case manager to influence HIV risk behavior change. Like case management, prevention case managers broker needed medical and psychosocial services, specifically those that influence HIV risk-taking such as STD and substance abuse treatment, thereby providing more efficient coordination of services. For example, an injecting drug user may have difficulty benefiting from HIV risk-reduction counseling without receiving substance abuse treatment.

3.0 DEVELOPING AND PLANNING A PCM PROGRAM

3.1 ORGANIZATIONAL CONTEXT AND CAPACITY

Factors related to organizational context and capacity may influence the potential effectiveness of a PCM program. These factors include the organization's physical setting, staffing capacity and skills, referral tracking capabilities, and the availability of, and access to, local referral sources.

PCM may be implemented from a variety of institutional or community-based settings. A review of PCM programs suggests, however, that "stand-alone" PCM programs - those programs independent of other preventive, medical, or social services, for example, health care, substance abuse treatment, and residential housing - have had more difficulty recruiting and retaining PCM clients [Purcell, DeGroff, Wolitski, Submitted for Publication]. PCM programs that are well integrated within a larger continuum of drug treatment, STD treatment, health care, or other social services may be more effective in recruiting and retaining clients. Thus, agencies that provide a spectrum of services and have strong relationships and/or alliances with outside providers in the community may be well positioned to support a PCM program, whereas "stand-alone" programs - those independent from other preventive, medical, or social services - are discouraged from considering a PCM program.

Second, the skills and capacity of staff are especially important for many of the services PCM programs provide. Prevention case managers require a broad array of sophisticated skills including assessment, prevention service planning, risk-reduction counseling, and crisis counseling. PCM targets those individuals with multiple, complex problems and risk-reduction needs; consequently, sophisticated skills are required of staff for some tasks (See Section 4.3 for more detail about staff qualifications).

Third, referral-tracking systems, computerized or otherwise, should be implemented to evaluate the effectiveness of a PCM program's referral system. This implies a level of organizational capacity to establish and confidentially maintain such a system.

Finally, the case management literature suggests that giving consideration to the available network of community support programs is important (Rubin 1992). The effectiveness of case management in general is related to both the availability of referral sources in the community and to supportive structural factors in the agency itself and the larger community system (Rothman 1992). Therefore, agencies considering a PCM program should first assess the availability of community services relevant to the target population and then evaluate their ability to develop and implement referral systems.

All these factors should be considered in determining whether or not your agency and community has the capacity to effectively support a PCM program.

3.2 DEVELOPING AN ORGANIZATION'S PROGRAM PLAN FOR PCM

3.2.1 HIV Prevention Community Planning

In 1994, the 65 state and local health departments that received CDC federal funds for HIV prevention began a participatory HIV prevention planning process. The goal of HIV prevention community planning is to improve the effectiveness of HIV prevention programs by strengthening the scientific basis, targeting, and community relevance of HIV prevention interventions. Together, representatives of affected populations, epidemiologists, behavioral scientists, HIV/AIDS prevention service providers, health department staff, and others analyze the course of the epidemic in their jurisdiction, determine their priority prevention needs, and identify HIV prevention interventions to meet those needs. Community planning groups are responsible for developing comprehensive HIV prevention plans that are directly responsive to the epidemics in their jurisdictions.

To proceed in developing a PCM program, the intended target population and PCM as an intervention should be consistent with the HIV prevention priorities identified in a jurisdiction's comprehensive HIV prevention plan.

3.2.2 Needs Assessment

In developing and planning a PCM program, a needs assessment is an essential first step. The needs assessment will assist in (1) establishing appropriate goals and objectives; (2) defining the purpose and scope of the program; (3) identifying social and behavioral attitudes, behaviors, and perceptions of the target community; (4) providing the basis for evaluation; and (5) establishing community-based support for the PCM program. This assessment should augment the epidemiologic profile and needs assessment described in the jurisdiction's comprehensive HIV prevention plan by providing additional, specific information needed for program design and implementation. These population characteristics will influence the range of PCM activities provided, the case manager's caseload, and recruitment and delivery strategies for a program. [More detailed information on conducting a needs assessment can be found in "Chapter 5: Assessing and Setting Priorities for Community Needs," Handbook for HIV Prevention Community Planning, Academy for Educational Development, April 1994. State and local health department program managers will also find information on conducting needs assessment in Planning and Evaluating HIV/AIDS Prevention Programs in State and Local Health Departments: A Companion to Program Announcement 300, Centers for Disease Control and Prevention, Reissued October 1996.]

3.2.3 Assessment of Community Resources

An assessment of community resources, including other HIV prevention programs and diagnosis and treatment services for substance abuse and for other STDs, is also essential - Results may influence the range of services provided by a PCM program and the skills needed by program staff. For instance, if a program is serving injecting drug users and few substance abuse treatment and prevention services are available, having program staff who are well trained in a variety of harm-reduction strategies is important. In other words, a PCM program should be tailored to the needs and characteristics of the population to be reached as well as to the available community services.

3.2.4 Goals and Objectives

A detailed program plan should be written that includes specific, time-phased, and measurable objectives for the PCM program. This plan should clearly define the goals and boundaries of the PCM program, including the roles to be assumed by prevention case managers. This has implications for staff training and resources. The plan should detail all parts of the PCM program including quality assurance and process evaluation measures.

4.0 IMPLEMENTING A PCM PROGRAM

4.1 CLIENT ELIGIBILITY

PCM is primarily intended for persons with multiple, complex problems and risk-reduction needs who are having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or reinfection. Priority for PCM services should be given to HIV seropositive persons. An agency may also serve HIV seronegative persons or those of unknown HIV serostatus if the individual identified for PCM is (1) a member of a community with moderate to high seroprevalence rates of HIV infection or (2) otherwise at heightened risk of HIV infection.

The following population groups are examples of those who may be appropriate for PCM, providing they meet the eligibility criteria just detailed (NOTE: This list is neither exclusive nor exhaustive):

1. Persons recently identified as HIV-infected by counseling and testing sites or partner notification services;
2. Partners of HIV-infected persons identified through referral or partner notification services;
3. Clients in substance abuse treatment or injecting drug users out of treatment who are accessing syringe exchange or harm-reduction programs.
4. Men who have sex with men (MSM), including young MSM;
5. Adults and teens repeatedly infected with STDs, especially HIV-positive persons, identified at health or STD clinics;
6. Clients of tuberculous (TB) clinics;
7. Adults recently released from corrections facilities with a history of substance abuse; and
8. Discordant couples with inconsistent condom use.

PCM program staff should emphasize the benefits of participation to potential clients, including assistance in identifying and addressing barriers to HIV risk reduction and assistance in accessing health and social services. Although some persons may present with a variety of acute medical and psychosocial needs, PCM is a voluntary service and should be reserved for individuals with a willingness to discuss their personal risk for HIV and to participate in HIV risk-reduction counseling on a regular basis. A review of PCM programs suggests that HIV seropositive persons may have stronger interest in participating in PCM programs. This review also finds that engaging high-need clients in HIV prevention activities, regardless of HIV serostatus, is difficult [Purcell, DeGroff, Wolitski, Submitted for Publication].

4.2 ESSENTIAL COMPONENTS OF A PCM PROGRAM

Each of the seven essential components of a PCM program is described in detail in the following sections.

4.2.1 Client Recruitment and Engagement

Each PCM program must have a comprehensive plan that contains explicit protocols to recruit and engage clients for PCM. Making a PCM program well-known and visible for those persons the program intends to serve is important. Recruitment strategies might include:

(6) enlisting the assistance of a street outreach program serving a similar target population to identify potential PCM clients;

(7) recruiting recently identified HIV seropositive persons from a counseling and testing site or partner notification service; or

(8) recruiting clients from other programs such as an STD clinic, a women's health clinic, or a drug treatment program.

In some cases, programs have used various incentives (for example, bus tokens, hygiene kits, tee shirts, and so on) to enhance recruiting efforts [Purcell, DeGroff, Wolitski, Submitted for Publication].

Acting quickly and early in the PCM process is important. Research shows that effective outreach and intake efforts are associated with a quick response time and assertive follow-up, a fact that has important implications for successful client recruitment in case management (Rothman 1992). For example, to ensure initial engagement in PCM, a program may require staff to follow up with each client a minimum of three or four times within the first 30 days, two of which must be in person.

STANDARD for Client Recruitment and Engagement

Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period.

4.2.2 Screening and Assessment

To maximize staff resources, potential PCM clients must be initially screened to ensure their eligibility for the service. Screening may include assessing risk behavior, intention, or readiness to change risk behavior (Prochaska and DiClemente 1992; Ajzen and Fishbein 1980). Case managers should also assess, over the course of the first three to four PCM sessions, a client's willingness and ability to participate in HIV risk-reduction counseling. If a potential client is found ineligible for PCM services, counseling and referrals relevant to their needs must be provided.

The need for a thorough assessment of clients' HIV, STD, and substance abuse risks, along with their medical and psychosocial needs, is essential for PCM. Assessment should identify behavioral factors that increase the risk for infection or transmission of HIV and other STDs. Assessment should also include the determination of whether or not the client has been HIV antibody tested and the client's knowledge of his or her HIV serostatus. The case manager should engage the client in a discussion that enables the client to recognize and accept personal risk for HIV. A client-centered approach to assessment is essential - the approach should be thorough and individualized for each client. Case managers should develop effective interactive methods to involve the client in identifying risk behaviors.

To provide the case manager with a more complete understanding of each client's medical and psychosocial needs and the overall context in which HIV risk behavior occurs, the following items should be assessed: health; adherence to HIV-related treatment; STD history; substance and alcohol use; mental health; sexual history; social and environmental support; skills to reduce HIV risk; intentions and motivations; barriers to safer behaviors; protective factors, strengths, and competencies; and demographic information. When combined, assessment activities should yield a comprehensive picture of the client's HIV prevention needs (PROCEED, Inc. 1997).

Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality (See Section 6.0, Ethical and Legal Issues).

Potential areas for assessment include the following:

Health This assessment should address access to medical care; current or chronic health conditions; HIV serostatus; date of last HIV antibody test; history of HIV-related opportunistic infections; date

of last TB test; TB status; and, for women, date of last gynecological exam, birth control methods, and pregnancy history.

Adherence to HIV-Related Treatment For persons living with HIV and receiving drug treatment, the assessment should address issues related to adherence to HIV-related treatment. Although new antiretroviral therapies have shown tremendous clinical benefit, ongoing concerns about adherence to complicated drug regimens and the likelihood of antiretroviral drug resistance are serious issues that must be actively addressed by prevention case managers. Areas for assessment within this category include adherence to antiretroviral therapies, adherence to treatments for opportunistic infections, barriers to adherence, factors facilitating adherence, and ability and intention to follow complex treatment regimens.

STD History The prevention, diagnosis, and treatment of STDs other than HIV is an essential component of any PCM program. The sequelae of untreated STDs can be serious. Untreated chlamydia and gonorrhea are two major contributors to preventable tubal infertility. Furthermore, acute STDs, particularly those involving lesions on the skin or mucous membrane, facilitate the transmission of HIV. Therefore, clients' history and treatment of STDs should be assessed as well as the date of their last STD medical evaluation.

Substance and Alcohol Use A number of factors related to substance and alcohol use should be assessed including the following: history of injecting drugs, alcohol use, and other non-injecting drug use; drug(s) of choice; frequency of use; route of administration; length of time using drugs/alcohol; frequency of needle sharing; treatment history; psychosocial context of drug/alcohol use; and affect of drug/alcohol use on sexual behavior. The potential relationship between substance use and unsafe sexual behaviors highlight the need for a comprehensive assessment of both injecting and non-injecting drugs.

Mental Health Several factors related to mental health should be considered including the following: family and personal mental health history; history of treatment, therapy, and hospitalization; adherence to treatment; suicidal ideation and history; and psychotropic medication history.

Sexual History A comprehensive sexual history is necessary to fully assess sexual risk behavior and related factors. Areas for assessment include number of sex partners; current partners (nature of relationships); HIV serostatus of partners; sexual behaviors practiced and frequency of behaviors; history of sexual abuse; role of alcohol and drugs during sex; involvement in sex in exchange for drugs/money/and so on; risk behaviors of partners; condom use, including barriers and facilitating factors for condom use; and knowledge of safer sex practices.

Social and Environmental Support Assessing key factors related to social and environmental support will provide a prevention case manager a more comprehensive picture of the context within which a client engages in risk behavior and of external factors potentially influencing risk behavior. Areas for assessment include the following: living situation; economic status; sources of income; employment; in or out of school, if youth; emotional support sources; history of incarceration; significant others; and connections to the community, for example, friends, family, church, and service providers.

Skills to Reduce HIV Risk Prevention case managers should assess the level of client skills in areas such as the following: use of condoms; sexual assertiveness; use of needle and syringe sterilization methods; use of safer injecting skills; and communication and negotiation skills.

Barriers to Safer Behavior A careful assessment of clients' perceived barriers to safer behavior is essential. Potential barriers include the following: knowledge of risk associated with unprotected intercourse and using unclean shared filters, cookers, and rinse and diluent water; availability of, and willingness to use, condoms and sterile syringes and injection equipment; potential for violence; legal concerns; cognitive or perceptual barriers; and personal and/or cultural barriers - values and norms around sexuality, drug use, or gender roles that affect risk behavior.

Protective Factors, Strengths, and Competencies Resources and factors that facilitate client's ability to stay healthy and practice safer behaviors should be assessed.

Demographic Information Basic demographic information should be collected including age, gender, race/ethnicity, sexual orientation, and education.

STANDARDS For Screening and Assessment

- PCM program staff must develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate clients for PCM.
- All persons screened for PCM, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager and referrals relevant to their needs.
- Thorough and comprehensive assessment instrument(s) must be obtained or developed to assess HIV, STD, and substance abuse risks along with related medical and psychosocial needs.
- All PCM clients must participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks and their medical and psychosocial needs.
- Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

4.2.3 Development of a Client-Centered Prevention Plan

A written client-centered Prevention Plan, based on information compiled from the assessment, must be developed. This plan should identify behavioral objectives to reduce the risk of acquiring or transmitting HIV that are time-phased, specific, and achievable. Both short- and long-term goals should be established by the client with the assistance of the case manager. Client participation is key because many clients are well aware of their goals and what would help them meet those goals (Rothman 1992). A client-centered approach will ensure that the Prevention Plan is responsive to the individual client's needs and circumstances. Therefore, prevention case managers should actively engage the client in setting behavioral objectives and identifying change strategies.

The Prevention Plan should identify effective change strategies that are reasonable and manageable for the client given his or her skills and circumstances. The Prevention Plan should specify who will be responsible for what and when (PROCEED, Inc. 1997). A high degree of specificity about the behaviors targeted for change, the interventions needed to implement change, and the expected outcomes should be included in the Prevention Plan.

For persons living with HIV and receiving medical treatments, secondary prevention interventions must focus on ensuring adherence to treatment for opportunistic infections and adherence to complex antiretroviral combination therapies. Secondary prevention interventions should also focus on maintaining the health of the client by ensuring the procurement of needed legal and entitlement services, treatment education, information on clinical care, and mental health services. The PCM Prevention Plan should detail the client's involvement, if eligible, in Ryan White CARE Act case management services along with other related programs or services. Further, the Prevention Plan should document efforts to ensure coordination and/or integration of PCM and Ryan White CARE Act case management.

The Prevention Plan must also outline efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status. This will require that PCM programs establish a strong relationship and referral mechanism with local STD service providers. As noted earlier in this document, the sequelae of untreated STDs can be serious and include infertility.

For clients with substance abuse problems, the Prevention Plan must address referral to appropriate drug and/or alcohol treatment. This will require that PCM programs establish strong relationships with local substance abuse providers if these services are not provided in-house. As discussed earlier in this document, the relationship between substance use and unsafe sexual behavior highlights the importance for securing appropriate treatment for those who need it. Furthermore, a substance-abusing client benefiting from HIV risk-reduction counseling without having received substance abuse treatment is unlikely.

Finally, client files that include individual Prevention Plans must be maintained in a locked file cabinet to ensure confidentiality.

STANDARDS for Development Of A Client- Centered Prevention Plan

- For each PCM client, a written Prevention Plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
- For persons living with HIV and receiving antiretroviral or other drug therapies, the Prevention Plan must address issues of adherence.
- The Prevention Plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status.
- For clients with substance abuse problems, the Prevention Plan must address referral to appropriate drug and/or alcohol treatment.
- Clients must sign-off on the mutually negotiated Prevention Plan to ensure their participation and commitment.
- Client files that include individual Prevention Plans must be maintained in a locked file cabinet to ensure confidentiality.

4.2.4 HIV Risk-Reduction Counseling

4.2.4.1 Client-Centered Counseling

Client-centered HIV risk-reduction counseling (that is, reducing the risk of acquiring or transmitting HIV) is the foundation of PCM. Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs (U.S. Department of Health and Human Services, May 1994). With a focus on meeting the identified behavioral objectives specified in the Prevention Plan, case managers must work with the client and apply a variety of strategies over multiple sessions to influence HIV risk behavior change. Depending on a client's readiness to change (Prochaska and DiClemente 1992), case managers should intervene to influence knowledge, perceived risk and vulnerability, intentions to change behavior, self-efficacy, skill levels, environmental barriers, relapse, and social support. Specific interventions for clients, regardless of HIV serostatus, may include skills building, individual counseling, couples counseling, crisis management, resource procurement, and preparation for referral of partners.

Counseling should be specifically tailored to the risk-reduction needs of each client. Table 1 summarizes factors that influence HIV risk behavior change (PROCEED, Inc. 1997 and Kelly 1992).

For persons of unknown HIV serostatus, interventions to prepare the client for HIV antibody testing may be appropriate. All clients must receive information regarding the potential benefits of knowing one's HIV serostatus. Counseling should explore barriers to testing faced by the client and seek to identify strategies to overcome these barriers. For individuals to make informed decisions about their health, early identification of HIV infection is important.

As part of client-centered counseling, PCM clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs. This counseling should also address the need for regular medical evaluation for STDs.

Finally, for seropositive clients, prevention case managers must discuss the notification of sex and needle-sharing partners who have been exposed to HIV. The purpose of notifying partners is to make them aware of their exposure to HIV and assist them in gaining access to counseling, testing, and other prevention and treatment services, including PCM, earlier in the course of infection (West and Stark 1997).

PCM program staff must develop a protocol for assisting seropositive clients in confidentially notifying partners and referring them to PCM and/or counseling and testing services. Two major approaches to partner notification have traditionally been applied by STD and HIV programs. Patient referral, when the patient or client notifies and refers his or her own sex and/or needle-sharing partners for testing, and provider referral, when health professionals, usually from the health department, notify the patient's partners of their exposure. Protocols for partner notification, within the context of PCM, should address the need for this service and be implemented at PCM enrollment or at any time clients potentially expose others while participating in the PCM program.

When clients choose to notify their own partners, prevention case managers should provide them with needed counseling, support, and skill building to ensure the successful confidential notification and referral of partners. Prevention case managers may invite clients to bring their partners to a PCM session, once notified, to provide partner counseling and ensure appropriate referrals to testing. Referral for medical evaluation and treatment of other STDs should be offered to all partners.

If the PCM client is unable or unwilling to notify partners himself/herself, the prevention case manager may facilitate notification by eliciting partner names and locating information and then, with the client's permission, requesting health department officials to confidentially notify partners. This approach requires that PCM programs establish an explicit relationship with health department officials to jointly carry out partner notification services. PCM program staff should be familiar with the health department's procedures for confidentially notifying partners and explain this process to clients. Finally, PCM programs may refer the client directly to the health department for assistance. Regardless of the approach used, partners identified may benefit from PCM services and should be assessed to determine their eligibility for the service.

Factor	Description	Elements of Effective Intervention
Knowledge About Risk	Accurate understanding of behaviors that confer risk, behavior changes needed to reduce risk, and the rationale underlying risk-reduction changes	Clear identification of behavior practices that create risk; practical advice on behavior changes needed to reduce risk, taking into account the realities of the client's lifestyle and relationships
Perceived Personal Vulnerability	Personalization of risk; believing one-self to be potentially vulnerable for contracting HIV/AIDS	Discussion that accurately communicates the client's risk level, encourages the client's self-appraisal of risk, and induces realistic perception of threat
Behavior Change Intention	Readiness for change and committing oneself to risk-reduction effort	Assessing, together with the client, his or her readiness for change and setting achievable risk-reduction goals through counseling and/or contracting
Self-Efficacy	Believing oneself capable of success-fully making risk-reduction behavior changes and perceiving that this change will protect against HIV/AIDS	Assigning incremental risk-reduction "tasks" that can easily be accomplished to establish a sense of competency and a success record; counseling that challenges a client's sense of fatalism
Skill Level	Behavioral competence in areas necessary for change implementation including condom use or other safer sex practices; sexual assertiveness skills to refuse risk pressures; safer sex negotiation skills; not sharing needles; use of clean needles; etc.	Skills training and practice; self-management or identification of patterns, habits, or activities that increase vulnerability to risk and development of alternative plan to address these behavioral "triggers"
Reinforcement of Behavior Change Efforts	Positive rather than negative outcomes associated with behavior change efforts, including positive partner response, self-praise, and reinforcement; belief that behavior change is consistent with peer group norms	Follow-up counseling contracts that suggest and reinforce change efforts, discussion of problems encountered, and encouragement of self-praise of risk-reduction change
Environmental Barriers	Experience fewer environmental constraints to perform a behavior rather than not to perform it	Discussion of barriers to performing risk-reduction behaviors; development of strategies to overcome those barriers and to create easier access to the resources required to enact change

Original table published by J. A. Kelly, "AIDS Prevention: Strategies That Work," AIDS Reader, July/August 1992, pp. 135–141; adapted with permission from version published by PROCEED, Inc., Standards and Considerations for Establishing HIV Prevention Case Management, 1997.

4.2.4.2 Partner Counseling

Including the client's partner in risk-reduction counseling sessions is appropriate within the context of PCM.

4.2.4.3 Secondary Prevention Counseling

Although PCM always involves primary prevention risk-reduction counseling, counseling related to secondary prevention for persons living with HIV is also appropriate within PCM. For instance, clients may need counseling support for accessing medical care and treatment. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to these treatments/therapies must be provided.

4.2.4.4 Substance Abuse and Mental Health Counseling

Although the emphasis of PCM is on HIV risk-reduction counseling, in some instances, some substance abuse and/or mental health counseling may need to be provided. In fact, counseling about strategies to avoid or modify substance abuse behaviors can be a form of HIV risk-reduction counseling. Such counseling should only be provided by staff skilled in these areas. Referring clients with these counseling needs to agencies with specific expertise in substance abuse and mental health counseling is optimal. However, if such services are unavailable and PCM staff have appropriate skills, short-term counseling focused on immediate living problems may be appropriate. Rothman (1992) found that counseling provided within case management is more effective when focused on information sharing, problem solving, reality testing, and socialization skills. PCM should not substitute for long-term therapy focused on long-standing personality issues or serious mental illness.

STANDARDS For HIV Risk-Reduction Counseling

- Multiple-session HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients.
- Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
- Clients who are not aware of their HIV antibody status must receive information regarding the potential benefits of knowing their HIV serostatus.
- Clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs.
- PCM program staff must develop a protocol for assisting HIV seropositive clients in confidentially notifying partners and referring them to PCM and/or counseling and testing services. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to treatments/therapies must be provided.

4.2.5 Coordination of Services with Active Follow-Up

The PCM program must establish a procedure for referring persons in a timely, efficient, and professional manner to sites providing services that may facilitate a client's ability to address and reduce his or her HIV risk behavior (for example, medical services, psychological treatment, substance abuse treatment, STD treatment, social services, and other HIV prevention services). Collaborative relationships

should be established with appropriate representatives of referral sites. PCM staff should actively assist clients in securing services at referral sites. Such assistance may include accompanying a client to an appointment, providing transportation services or bus/rail tokens, ensuring the provision of child-care services, ensuring translation or interpretation services, and providing client skills-building to support his/her ability to effectively advocate on behalf of himself/herself with other providers.

Effective coordination of services necessitates that PCM programs have current, accurate community provider information on hand. This information should include hours of operation, addresses, phone numbers, accessibility to public transportation, eligibility requirements, and information regarding materials required at application such as bringing a driver's license, birth certificate, and so forth.

Most PCM clients may be already receiving services from other providers. Therefore, coordination of services also involves collaboration with an individual client's other case managers or counselors (for example, substance abuse counselor, Ryan White CARE Act case manager, probation officer, or housing or shelter supervisor). Such collaboration benefits the client and avoids duplication of services. Communication about an individual client with other providers is dependent upon the obtainment of written, informed consent from the client.

Finally, PCM program staff must have methods in place to follow up on referrals to assess the outcome, for example, whether or not the client received the needed service.

STANDARDS for Coordination of Services with Active Follow-Up

- Formal and informal agreements, such as memoranda of understanding, must be established with relevant service providers to ensure availability and access to key service referrals.
- A standardized written referral process for the PCM program must be established.
- Explicit protocols for structuring relationships and communication between case managers or counselors in different organizations is required to avoid duplication of services, for example, how to transfer or co-manage PCM clients with Ryan White CARE Act case management.
- Communication about an individual client with other providers is dependent upon the obtainment of written, informed consent from the client.
- A referral tracking system must be maintained.
- Annual assessment of relevant community providers with current referral and access information must be maintained.
- A mechanism to provide clients with emergency psychological or medical services must be established.

4.2.6 Monitoring and Reassessing Clients' Needs and Progress

Regular, structured meetings must be carried out between the prevention case manager and the client to assess the client's changing needs, monitor progress, and revise the Prevention Plan accordingly. In addition, HIV risk-reduction counseling must be provided at all appropriate opportunities. As mentioned previously, case managers should regularly inquire about recent sex and needle-sharing partners of seropositive clients.

If partners were potentially exposed to HIV, steps should be taken as outlined in Section 4.2.5 to inform them and encourage their participation in PCM and/or counseling and testing services. Assessment

of progress in meeting the Prevention Plan objectives should be communicated to the client for review and discussion. Home visits, if appropriate, may provide a valuable opportunity for case managers to gain a comprehensive impression of the client's social and environmental support. Individual meetings with a client must be reflected in the client's progress notes.

As individual client's progress in a PCM program and psychosocial needs are met, their needs may become less acute. Piette et al. (1992) describes the use of "high-" and "low-need" client categories with separate protocols for frequency and type of interaction to manage caseloads. Assigning individual prevention case managers a balance of new PCM clients (presumably higher need) and continuing clients (lower need) may also reduce staff burn-out. Regardless of the staffing or triage system applied, monitoring ability is enhanced with a manageable caseload and adequate case records (Piette et al. 1992).

Retention of PCM clients is a concern (CDC 1997) [Purcell, DeGroff, Wolitski, Submitted for Publication]; therefore, program staff must define minimum levels of effort to reach clients for follow-up. For instance, a program should determine how many attempts - telephone calls, field visits, and so on - will be made before a client is made "inactive."

STANDARDS for Monitoring and Reassessing Clients' Needs and Progress

- Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes.
- A protocol must be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made "inactive."

4.2.7 Discharge from PCM upon Attainment and Maintenance of Risk-Reduction Goals

In establishing a Prevention Plan, the prevention case manager and client will determine the appropriate time commitment for completing the plan. This will be based on client characteristics, needs, stated Prevention Plan objectives, and PCM activities provided.

PCM is a time-limited prevention activity intended to meet achievable behavioral objectives - identified by assessment and prevention planning - through counseling, service brokerage, and monitoring. PCM is not intended to substitute for extended social services or psychological care. Once the client has accomplished the behavioral objectives set forth in the Prevention Plan, a determination must be made by the client and prevention case manager that the client is ready for discharge (for example, a client is made "inactive" or "graduates," and PCM services are terminated). At the time of discharge, the prevention case manager, together with the client, should make every effort to ensure that the client is connected to needed resources and services.

In cases when the client has achieved his or her behavioral objectives, but actively experiences relapse to unsafe behaviors and faces on-going barriers to risk reduction, continuation of PCM services may be warranted. For these clients, PCM services may emphasize continued risk-reduction counseling.

Standard for Discharge From PCM Upon Attainment and Maintenance of Risk-Reduction Goals

A protocol for client discharge must be established.

4.3 STAFF QUALIFICATIONS

In considering staff qualifications, detailing the related PCM activities, such as assessment, prevention planning, and risk-reduction counseling, and defining appropriate levels of staff training and skills for each, may be valuable. Agency managers may choose to have professionally trained staff serve as prevention case managers and carry out all PCM activities from recruitment and engagement through discharge. Other agency managers may apply a team approach to PCM, using both professionals and paraprofessionals. Paraprofessionals, under the supervision of a case manager, may be effective in assisting with functions such as recruitment, screening, and follow-up assistance to ensure coordination of care. Professionals may be more appropriate for performing the functions of PCM requiring more sophisticated skills such as assessment, prevention planning, and HIV risk-reduction counseling. If a team approach is used, an explicit, structured means for professionals, paraprofessionals, and volunteers to communicate must exist. Staff qualifications, then, should be based on the skills required to complete the various PCM functions or activities. All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

The essential components of a PCM program along with suggested minimum staff qualifications can be grouped into the following two main categories:

1. Essential Components

Client recruitment and engagement, screening, and coordination of services.

Suggested Minimum Staff Qualifications:

Knowledge of target population; cultural and linguistic competence; knowledge of HIV, AIDS, and other STDs; knowledge of available community services; and effective communication skills.

2. Essential Components

Assessment, development of a Prevention Plan, HIV risk-reduction counseling, monitoring and reassessment, on-going support and relapse prevention, graduation and discharge planning.

Suggested Minimum Staff Qualifications

A bachelor's degree or extensive experience in a human-services-related field, such as social work, psychology, nursing, counseling, or health education; skilled in case management and assessment techniques; skill in counseling; ability to develop and maintain written documentation (case notes); skill in crisis intervention; knowledgeable of HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change principles and strategies; and cultural and linguistic competence.

PCM supervisors need the academic training and/or experience to adequately develop an overall PCM program, including PCM program goals and objectives, PCM protocols, and quality assurance and evaluation measures. PCM supervisors should also have management skills and experience overseeing case management staff. PCM program managers should provide an orientation to the PCM program for new workers and on-going supervision to ensure that the PCM intervention is clearly understood. On-going staff training and development is essential to build staff skills.

STANDARDS for Staff Qualifications

- Staff must be provided written job descriptions and opportunities for regular, constructive feedback. In addition, staff must be provided opportunities for regular training and development.
- Organizations must hire case managers with the appropriate training and skills to complete the PCM activities within their job description.
- All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

4.4 CASELOAD

Depending on client characteristics, needs, and PCM activities provided, an ideal caseload for a full-time prevention case manager may range from 20 to 35 clients (Rubin 1992). Caseload will vary based on the complexities of individual cases and the length of time clients are served. In service areas where fewer resources are available, prevention case managers may be expected to go beyond the HIV risk-reduction counseling and resource-linking roles and become providers of other direct services, if they have the appropriate skills. Such circumstances will decrease the number of clients each case manager can effectively serve.

When case managers deliver many direct services and/or when clients are younger, harder to engage in treatment, or more vulnerable to negative social forces such as poverty or homelessness, smaller caseloads are expected (Rubin 1992). Also, with smaller, more intensive caseloads, case managers may develop a more therapeutic relationship with the client. In contrast, if case managers are working primarily with low-need clients, the caseload would be expected to be higher.

4.5 COORDINATION OF PCM WITH RYAN WHITE CARE ACT CASE MANAGEMENT

The Ryan White CARE Act funds case management services for persons living with HIV or AIDS to ensure coordination and continuity of needed entitlement, medical care and treatment, housing, and other social services (See Appendix C). Eligibility for Ryan White CARE Act case management services are established at the local level by Ryan White planning councils. Because of the obvious potential for service duplication between PCM and Ryan White CARE Act case management, explicit attention to coordination of these services is essential.

Foremost, PCM is intended as an HIV primary prevention activity (to reduce the transmission and acquisition of HIV infection) and must never duplicate Ryan White CARE Act case management services. However, PCM services may be integrated into Ryan White CARE Act case management. The integration of these two services will be influenced by the eligibility requirements for Ryan White CARE Act case management in a given community, the extent of primary HIV prevention provided by Ryan White CARE Act case managers, and the range of services provided by both case management services. Together, a Ryan White Care Act case manager and a prevention case manager can determine which services are most appropriate to be provided by each. To ensure effective coordination between these two services, PCM program staff must establish explicit relationships for coordination and/or integration with Ryan White CARE Act case management providers in their jurisdiction and be knowledgeable of local Ryan White CARE Act case management eligibility criteria. Effective coordination of Ryan White case management and PCM services will benefit the client.

STANDARDS for Coordination Of PCM With Ryan White Care Act Case Management

- An explicit protocol for structuring relationships with Ryan White CARE Act case management providers must be established and should detail how to transfer and/or share clients.
- PCM must not duplicate Ryan White CARE Act case management for persons living with HIV, but PCM may be integrated into these services.

5.0 EVALUATION

5.1 QUALITY ASSURANCE

Quality assurance is essential to make certain that delivery of quality PCM services are consistent and to ensure that interventions are delivered in accordance with established standards. Project RESPECT, a study of HIV prevention counseling, emphasized quality assurance measures to maintain high performance expectations of staff and ensure consistent and comprehensive delivery of the counseling interventions (Kamb, Dillon, Fishbein, Willis, and Project RESPECT Study Group 1996).

For PCM, clear procedure and protocol manuals are necessary to ensure effective delivery of services and minimum standards of care. These manuals should address all the standards contained in this document (See Appendix B for concise list) and should be available to all staff. Written quality assurance protocols must be developed by PCM programs and should be included in procedure and protocol manuals. Client feedback should be routinely used as a factor in assessing the quality assurance of PCM services provided. Quality assurance mechanisms include the following:

Written Protocols Descriptions of specific communication-related activities, such as protocols for client engagement and follow-up, screening, risk-reduction counseling, partner notification, and so forth.

Training Training for supervisors and staff to ensure appropriate skills to complete the PCM activities within their job descriptions.

Individual Supervision Regular review of each staff member's performance, productivity level, and quality of services provided.

Chart Reviews Regular review of individual client's PCM assessment, Prevention Plan, and progress notes by the case management supervisor to ensure clear documentation and appropriate intervention.

Case Conferences and Presentations Regular presentation of cases, especially those that are complex and difficult, by case managers to peers and supervisors to discuss a client's progress and strategies for intervention.

Peer Review Regular review by a convened panel or peer group of performance and quality of services being delivered.

Client Satisfaction Surveys or Interviews Routine feedback from clients about their satisfaction with the service, their concerns, and their ideas for improvement.

Independent Program Audits Reviews and evaluations from panels of professionals from outside the agency on the quality of the program, including assurance that the program is delivering the

services it is promoting. Special attention must be given to ensuring the confidentiality of clients when independent program audits are conducted.

STANDARDS for Quality Assurance

- Clear procedure and protocol manuals for the PCM program must be developed to ensure effective delivery of PCM services and minimum standards of care.
- Written quality assurance protocols must be developed and included in procedure and protocol manuals.
- Client PCM records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client's signature.

5.2 PROGRAM EVALUATION

All PCM programs should conduct process evaluation. Process evaluation provides a descriptive assessment of a program's actual operation and the level of effort taken to reach desired results (that is, what was done, to whom, and how, when, and where). Process evaluation is intended for program improvement. Process evaluation measures may be both quantitative and qualitative in nature. Possible process evaluation measures for a PCM program include the following:

- Demographic information of clients,
- Risk profiles of clients,
- Health status of clients,
- Service referrals offered and followed through,
- Number and length of PCM sessions provided,
- Client satisfaction surveys, and
- Review of quality assurance measures.

Some programs may have the capacity to conduct outcome evaluation, the assessment of the immediate or direct effects of a program on the program participants (for example, the degree to which the program increased knowledge of HIV/AIDS, perceived risk of infection, and/or decreased intent of engaging in risk behaviors related to HIV transmission). Outcome evaluation also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population. Agencies interested in conducting outcome evaluation are encouraged to involve program evaluation experts. To date, PCM programs generally have not been required or funded to conduct outcome evaluation.

6.0 ETHICAL AND LEGAL ISSUES

All of the following issues have critical ethical and legal implications for PCM programs.

STANDARDS for Ethical and Legal Issues

Confidentiality Organizations must have well-established policies and procedures for handling and maintaining HIV-related confidential information that conform to state and federal laws. These policies and procedures must ensure that strict confidentiality is maintained for all persons who are screened, assessed, and/or participate in PCM. Most states have well-established and stringent confidentiality laws specifically related to information about HIV/AIDS.

Voluntary and Informed Consent A client's participation must always be voluntary and with the client's informed consent. Documentation of voluntary, informed consent must be maintained in the client's file. In addition, a client's informed consent is required before a prevention case manager may contact another provider serving that same client.

Cultural Competence Organizations must make every effort to uphold a high standard for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population. Cultural appropriateness and relevance are critical to the success of any HIV prevention activity.

Professional Ethics PCM must be governed by the same general professional ethics that govern most human service fields such as social work, counseling, and clinical psychology (For example, Hepworth, D. H. and Larsen, J. 1986).

Discharge Planning Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at the time of discharge (graduation).

Duty to Warn Organizations must be familiar with state and local procedures/requirements related to duty to warn other individuals at risk or in physical danger.

7.0 TECHNICAL ASSISTANCE

CDC project officers in the Division of HIV/AIDS Prevention - Intervention Research and Support, National Center for HIV, STD, and TB Prevention are available to provide technical assistance to grantees in interpreting and applying these guidance and standards.

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APPENDIX A

GLOSSARY

Client-Centered Counseling Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs. The focus is on developing prevention objectives and strategies with the client rather than simply providing information. An understanding of the unique circumstances of the client is required - behaviors, sexual identity, race/ethnicity, culture, knowledge, and social and economic status.

Cultural Competence In the context of PCM, services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population.

Patient Referral In the context of notifying sex and needle-sharing partners, when the patient, that is client, notifies and refers his or her own partners for testing.

Provider Referral In the context of notifying sex and needle-sharing partners, when health professionals, usually from the health department, notify the patient's partners of their exposure.

Medical and Psychosocial In the context of PCM, "medical" and "psychosocial" encompasses the medical, psychological, and social domains of an individual.

Outcome Evaluation Outcome evaluation involves the assessment of the immediate or direct effects of a program on the program participants, for example, the degree to which the program increased knowledge of HIV/AIDS, perceived risk of infection, and/or decreased intent of engaging in risk behaviors related to HIV transmission. Outcome evaluation also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population.

Prevention Case Management PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, on-going, and individualized prevention counseling, support, and service brokerage.

Primary Prevention The aim of primary prevention is to reduce the incidence of disease and injury (Last and Wallace 1992). As related to HIV prevention, the aim of primary prevention is to reduce the transmission and acquisition of HIV infection through a variety of strategies, activities, interventions, and services.

Process Evaluation Process evaluation provides a descriptive assessment of a program's actual operation and the level of effort taken to reach desired results, that is, what was done, to whom, and how, when, and where.

Secondary Prevention The aim of secondary prevention is to reduce the prevalence of disease and disability (Last and Wallace 1992). As related to HIV prevention, the aim of secondary prevention is to prevent a person living with HIV from becoming ill or dying as a result of HIV, opportunistic infections, or AIDS through a variety of strategies, activities, interventions, and services.

APPENDIX B

STANDARDS FOR PCM PROGRAMS

CLIENT RECRUITMENT AND ENGAGEMENT

- Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period.

SCREENING AND ASSESSMENT

- PCM program staff must develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate clients for PCM.
- All persons screened for PCM, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager and referrals relevant to their needs.
- Thorough and comprehensive assessment instrument(s) must be obtained or developed to assess HIV, STD, and substance abuse risks along with related medical and psychosocial needs.
- All PCM clients must participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks and their medical and psychosocial needs.
- Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

DEVELOPMENT OF A CLIENT- CENTERED PREVENTION PLAN

- For each PCM client, a written Prevention Plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
- For persons living with HIV and receiving antiretroviral or other drug therapies, the Prevention Plan must address issues of adherence.
- The Prevention Plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status.
- For clients with substance abuse problems, the Prevention Plan must address referral to appropriate drug and/or alcohol treatment.
- Clients must sign-off on the mutually negotiated Prevention Plan to ensure their participation and commitment.
- Client files that include individual Prevention Plans must be maintained in a locked file cabinet to ensure confidentiality.

HIV RISK-REDUCTION COUNSELING

- Multiple-session HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients.
- Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
- Clients who are not aware of their HIV antibody status must receive information regarding the potential benefits of knowing their HIV serostatus.

- Clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs.
- PCM program staff must develop a protocol for assisting HIV seropositive clients in confidentially notifying partners and referring them to PCM and/or counseling and testing services. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to treatments/therapies must be provided.

COORDINATION OF SERVICES WITH ACTIVE FOLLOW-UP

- Formal and informal agreements, such as memoranda of understanding, must be established with relevant service providers to ensure availability and access to key service referrals.
- A standardized written referral process for the PCM program must be established.
- Explicit protocols for structuring relationships and communication between case managers or counselors in different organizations is required to avoid duplication of services, for example, how to transfer or co-manage PCM clients with Ryan White CARE Act case management.
- Communication about an individual client with other providers is dependent upon the obtainment of written, informed consent from the client.
- A referral tracking system must be maintained.
- Annual assessment of relevant community providers with current referral and access information must be maintained.
- A mechanism to provide clients with emergency psychological or medical services must be established.

MONITORING AND REASSESSMENT OF CLIENTS' NEEDS AND PROGRESS

- Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes.
- A protocol must be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made "inactive."

DISCHARGE FROM PCM UPON ATTAINMENT AND MAINTENANCE OF RISK-REDUCTION GOALS

- A protocol for client discharge must be established.

STAFF QUALIFICATIONS

- Staff must be provided written job descriptions and opportunities for regular, constructive feedback. In addition, staff must be provided opportunities for regular training and development.
- Organizations must hire case managers with the appropriate training and skills to complete the PCM activities within their job description.
- All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

COORDINATION OF PCM WITH RYAN WHITE CARE ACT CASE MANAGEMENT

- An explicit protocol for structuring relationships with Ryan White CARE Act case management providers must be established and should detail how to transfer and/or share clients.
- PCM must not duplicate Ryan White CARE Act case management for persons living with HIV, but PCM may be integrated into these services.

QUALITY ASSURANCE

- Clear procedure and protocol manuals for the PCM program must be developed to ensure effective delivery of PCM services and minimum standards of care.
- Written quality assurance protocols must be developed and included in procedure and protocol manuals.
- Client PCM records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client's signature.

ETHICAL AND LEGAL ISSUES

Confidentiality

- Organizations must have well-established policies and procedures for handling and maintaining HIV-related confidential information that conform to state and federal laws.
- These policies and procedures must ensure that strict confidentiality is maintained for all persons who are screened, assessed, and/or participate in PCM.
- Most states have well-established and stringent confidentiality laws specifically related to information about HIV/AIDS.

Voluntary and Informed Consent

- A client's participation must always be voluntary and with the client's informed consent.
- Documentation of voluntary, informed consent must be maintained in the client's file.
- In addition, a client's informed consent is required before a prevention case manager may contact another provider serving that same client.

Cultural Competence

- Organizations must make every effort to uphold a high standard for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population.
- Cultural appropriateness and relevance are critical to the success of any HIV prevention activity.

Professional Ethics

- PCM must be governed by the same general professional ethics that govern most human service fields such as social work, counseling, and clinical psychology.

Discharge Planning

- Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at the time of discharge (graduation).

Duty to Warn

- Organizations must be familiar with state and local procedures/requirements related to duty to warn other individuals at risk or in physical danger.

APPENDIX C: RYAN WHITE CARE ACT PROGRAMS

The Health Resources and Services Administration (HRSA) is one of eight agencies in the U.S. Department of Health and Human Services. Within HRSA four bureaus provide funding for the delivery of HIV/AIDS care, services (including case management), and training - the Bureau of Health Resources Development (BHRD), Bureau of Primary Health Care (BPHC), Bureau of Maternal and Child Health (MCHB), and Bureau of Health Professions (BHPr).

Each of the four HRSA bureaus conducts programs to benefit low-income, uninsured, and underinsured individuals and families affected by HIV/AIDS through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. HRSA's AIDS Program Office (1) provides direction; (2) coordinates HIV/AIDS health care-related activities across the bureaus; and (3) works with other federal and state agencies, providers, and constituent groups to identify emerging issues and needs and to facilitate integrated, client-oriented HIV/AIDS services.

Signed into law on August 18, 1990, the Ryan White CARE Act was named after the Indiana teenager, Ryan White, who became an active public educator on HIV/AIDS after he contracted the disease. He died that same year. The act, which was amended in May 1996, provides assistance to improve the quality and availability of care for people with HIV/AIDS and their families.

HRSA administers HIV/AIDS programs under four titles and Part F of the act, which are described as follows:

Title I - HIV Emergency Relief Grant Program for Eligible Metropolitan Areas Title I is administered by BHRD's Division of HIV Services. This program provides formula and supplemental grants to Eligible Metropolitan Areas (EMAs) that are disproportionately affected by the HIV epidemic. For an area to be eligible, it must have a population of 500,000 or more and have reported more than 2,0**00 AIDS cases in the preceding 5 years.**

Title II - HIV Care Grants to States Title II is also administered by BHRD's Division of HIV Services and provides formula grants to states, U.S. territories, the District of Columbia, and Puerto Rico to provide health care and support services for people with HIV/AIDS. Grants are awarded based on (1) the estimated number of living AIDS cases in the state or territory; and (2) the estimated number of living AIDS cases within the state or territory but outside of Title I EMAs (that is, outside an area with 500,000+ population and 2,000+ AIDS cases/previous 5 years). Additionally, grantees must provide therapeutics to treat HIV/AIDS under the AIDS Drug Assistance Program (ADAP).

Title III(b) - HIV Early Intervention Services BPHC's Division of Programs for Special Populations administers Title III(b) of the act through the Early Intervention Services Program. This program supports outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. Medical, educational, and psychosocial services are designed to prevent the further spread of HIV/AIDS, delay the onset of illness, facilitate access to services, and provide psychosocial support to people with HIV/AIDS.

Title IV - Coordinated HIV Services and Access to Research for Children, Youth, Women, and Families Title IV is a special grant program directed by MCHB to coordinate HIV services and access to research for children, youth, women, and families in a comprehensive, community-based, family-centered system of care.

Part F - Special Projects of National Significance Program BHRD's Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program to support the development of innovative models of HIV/AIDS care. These models are designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations. Additionally, they are expected to be replicable and have a strong evaluation component. Integrated service delivery models were funded in Fiscal Year 1996 to create formal linkages to integrate health and support services.

Part F - AIDS Education and Training Centers Fifteen AIDS Education and Training Centers (AETCs) have been established under BHPr. The AETCs are a national network of centers that conduct targeted, multidisciplinary education and training programs for health care providers in designated geographic areas. The AETCs increase the number of health care providers who are educated and motivated to counsel, diagnose, treat, and manage care for individuals with HIV/AIDS and to help prevent high risk behaviors that may lead to further HIV transmission.

Part F - AIDS Dental Reimbursement Program BHPr also administers the AIDS Dental Reimbursement Program. This grant program assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV-positive patients.

For additional information on the Ryan White CARE Act, contact

HRSA AIDS Program Office
5600 Fishers Lane, Room 14A-21
Rockville, MD 20857
Phone: 301-443-4588
Fax: 301-443-1551

Adapted, with permission, from HRSA's AIDS Program Office, "HRSA Fact Sheet," March 1997.

Partner Counseling and Referral Services (PCRS)

PCRS provides a systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Counseling and testing refers to the voluntary process of HIV testing accompanied by client-centered, interactive information-sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, and how to prevent the transmission and acquisition of HIV infection. In the best of situations, the individual also receives tailored support on how to adapt this information to his or her life.

Referral is the process by which individuals with high-risk behaviors and those infected with HIV are guided towards prevention, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs.

Voluntary partner notification is the voluntary process by which sex and needle-sharing partners of a person who is either HIV positive or at high-risk for HIV are located, informed of their possible risk, and encouraged to seek counseling and testing for themselves.

The **standards** for PCRS are included in the following document, the CDC **Guidance** for PCRS.

HIV Partner Counseling, Testing and Referral Services

Standards and Guidelines

US Department of Health & Human Services
Public Health Service
Centers for Disease Control and Prevention
December 1998

Preface

This guidance uses new terminology to label the process of reaching and serving sex and needle-sharing partners. As opposed to *contact tracing and partner notification*, the term *partner counseling and referral services* (PCRS) is used in this document because it better reflects the type and range of public health services that are recommended for sex and needle-sharing partners. These services are vital to any community' s HIV prevention efforts. This guidance should assist in developing programs, planning services, or prioritizing resource allocation for PCRS, and state and local programs supported with CDC funds should adapt it to meet their local policies, needs, and circumstances.

The principles listed on the following pages constitute the basis for PCRS and are applied to issues discussed throughout this document. Principles 1-8 apply to partner counseling and referral services associated with partner services for all sexually transmitted diseases, including HIV. Principles 9-13 apply to partner counseling and referral services associated with HIV in particular.

1. **Voluntary.** PCRS is voluntary on the part of the infected person and his or her partners.
2. **Confidential.** Every part of PCRS is confidential.
3. **Science-Based.** PCRS activities are science-based and require knowledge, skill, and training.
4. **Culturally Appropriate.** PCRS is to be delivered in a nonjudgmental, culturally appropriate, and sensitive manner.
5. **A Component of a Comprehensive Prevention System.** PCRS is one of a number of public health strategies to control and prevent the spread of HIV and STDs. Other strategies include access to clinical services, outreach to and targeted screenings of at-risk populations, behavioral interventions, and educational programs.
6. **Diverse Referral Approaches.** PCRS may be delivered through two basic approaches: provider referral, whereby the PCRS provider locates and informs sex or needle-sharing partners of their exposure, and client referral, whereby the infected person takes responsibility for informing his or her partners. Sometimes a combination of these approaches is used.
7. **Support Services and Referral.** PCRS is delivered in a continuum of care that includes the capacity to refer sex and needle-sharing partners to HIV counseling, testing, and treatment, as well as other services, e.g., STD treatment, family planning, violence prevention, drug treatment, social support, housing.
8. **Analysis and Use of PCRS Data.** PCRS program managers should collect data on services provided and use the data for evaluating and improving program efficiency, effectiveness, and quality.
9. C**ounseling and Support for Those Who Choose To Notify Their Own Partners**. Counseling and support for those who choose to notify their own partners is an essential element of PCRS. Such efforts can assist in ultimately reaching more partners and minimizing unintended consequences of notification. Assistance to clients in deciding if, how, to whom, where, and when

to disclose their infection can help them avoid stigmatization, discrimination, and other potential negative effects. Working with a client to think through what it means to notify a partner and creating a specific plan to ensure he or she successfully accomplishes the notification is a vital role of the provider.

10. **Client-Centered Counseling.** Providing client-centered counseling for HIV-infected individuals and their partners can reduce behavioral risks for acquiring or transmitting HIV infection. In addition, client-centered counseling will help the provider understand the readiness of the client to notify partners. This will allow the provider to offer services to assist the client in successfully notifying partners without adverse consequence.
11. **Increased Importance as New Technologies Emerge.** As new technologies emerge, such as rapid diagnostic tests, vaccines, behavioral interventions, and even more effective therapies, PCRS will become an increasingly important prevention tool.
12. **Ongoing Access to PCRS for HIV-Infected Individuals and Partners.** PCRS should not be a one-time service. It should be offered as soon as an HIV-infected individual learns his or her serostatus and made available throughout that person' s counseling and treatment. If new partners are exposed in the future, PCRS should be made available again. HIV-infected individuals should have the ability to access PCRS whenever needed.
13. **Assistance in Accessing Medical Evaluation and Treatment To Prolong Life.** Sex and needle-sharing partners might already be HIV-infected but be unaware of or deny their risks. They can be assisted through PCRS in learning their status, and in obtaining earlier medical evaluation and treatment for HIV disease and opportunistic infections. PCRS provides an opportunity for HIV primary prevention interventions for those partners not infected with HIV and an opportunity for secondary prevention for those partners living with HIV.

How to use this document

The standards and guidance in this document describe the core elements that are essential for successful PCRS programs at publicly funded sites. Even though HIV and STD programs share many common goals, policies, and activities, PCRS is designed specifically for HIV prevention programs. It is not intended to replace or modify CDC guidance for partner notification for other STDs.

The two levels of recommendations in this document are **Standards** and **Guidance:**

Standards. Specific standards are provided in several sections in boxed text and are intended to be applied consistently. **Standards must be followed** by CDC grantees in virtually all cases where CDC funds are used to support services.

Guidance. The main text of this document provides overall guidance for PCRS programs. **This guidance *should* be followed** in most cases, but can be tailored to fit the individuals and affected communities being served as well as the program needs. Providers are urged to follow this guidance but have flexibility to modify or adapt based on state or local needs, policies, or

1.1 How HIV PCRS Has Evolved

Once known as "contact tracing," outreach activities for finding, diagnosing, and treating partners of persons infected with sexually transmitted diseases (STDs) have long been used by public health workers as a prevention activity. In the 1930s, U.S. Surgeon General Thomas Parran advocated the use of contact tracing to help "prevent new chains of [syphilis] infection" (Parran, 1937). Contact tracing was later expanded to include partners of persons infected with gonorrhea and other STDs, including the human immunodeficiency virus (HIV), and came to be known in the 1980s as "partner notification" (West and Stark, 1997).

In the 1980s, when public health workers were first being confronted with the rapid spread of HIV, the virus that causes acquired immunodeficiency syndrome (AIDS), informing persons of their possible exposure to HIV and offering counseling, testing, and referral services were already recognized as an important disease prevention effort that could help stem the tide of HIV infection. As HIV prevention activities have evolved, so has the terminology for informing the HIV-infected person's sex and needle-sharing partners of their possible exposure to the virus. Today, the term *HIV partner counseling and referral services (PCRS)* more accurately reflects the range of services available to HIV-infected persons, their partners, and affected communities through this public health activity.

Of necessity, PCRS for HIV differs from partner services for other STDs because the "epidemiological, biological, and clinical characteristics of HIV are different" (West and Stark, 1997). Despite recent advances in treatment, we do not yet have a cure for AIDS, so HIV remains a lifelong issue for those infected. Furthermore, because society frequently stigmatizes and sometimes discriminates against HIV-infected persons and their families and friends, the affected communities may be concerned about the potential negative impact of PCRS. HIV prevention programs need affected communities to be involved in and understand PCRS for the overall prevention efforts to be accepted and effective.

Federal and state legislative mandates in the 1990s have underscored the importance of notifying sex and needle-sharing partners of their possible exposure to HIV. Recent examples include the federal requirement to notify spouses of HIV-infected persons (Public Law 104-146, Section 8[a] of the Ryan White CARE Reauthorization Act of 1996) and state legislation to require health departments to offer HIV partner notification services to newly reported HIV-infected persons (National Council of State Legislators, 1998). Legal and ethical concepts such as the rights of individuals to know their risk of infection, to learn their HIV status anonymously or confidentially, and to be protected against discrimination if HIV-infected, will continue to drive public health policies and legislative action on HIV PCRS (West and Stark, 1997). Public health policies and legislative actions related to the above concepts will determine, at least in part, how PCRS is conducted.

1.2 What Are the Goals of PCRS?

PCRS is a prevention activity with the following goals:

- Providing services to HIV-infected persons and their sex and needle-sharing partners so they can avoid infection or, if already infected, can prevent transmission to others.
- Helping partners gain earlier access to individualized counseling, HIV testing medical evaluation, treatment, and other prevention services.

Through PCRS, persons - many of whom are unsuspecting of their risk - are informed of their exposure or possible exposure to HIV. Notified partners can choose whether to be tested, and if not tested or if found to be uninfected, can receive counseling about practicing safer behaviors to avoid future exposure to HIV. If, however, they are found to be infected, they can seek early medical treatment and practice behaviors that help prevent transmission of HIV to others and reduce the risk of becoming infected with other STDs.

PCRS can be instrumental in identifying sexual and drug-injecting networks at high risk for transmission of HIV or other sexually transmitted diseases (Fenton and Peterman, 1997; West and Stark, 1997). These networks are made up of individuals who share social relationships involving sex or drug use. Such networks can be identified and described at least partly through information obtained by PCRS activities (West and Stark, 1997). Future prevention interventions can then be more effectively directed, and the HIV risks within the network(s) potentially reduced. Network research, combined with new methods of virus typing and identification of recently infected persons (Janssen, *et al.*, 1998), will contribute to a greater understanding of HIV transmission (Fenton and Peterman, 1997).

1.3 Is PCRS Cost-effective?

Some have raised concerns about the high potential cost of PCRS and have questioned on these grounds whether or not it should be supported. In fact, although the relative investment per person reached might be greater than other public health activities, PCRS is likely to be highly cost-effective. A simple threshold analysis illustrates the probable cost-effectiveness of PCRS to society. Assuming an estimated current $154,402 lifetime cost in the United States of a person acquiring HIV infection and eventually dying from HIV-related illness (Holtgrave and Pinkerton, 1997) and a conservatively estimated average $3,205 cost of PCRS to reach one infected person (Toomey *et al.*, 1998), PCRS must prevent 1 infection out of every 51 HIV-infected partners reached through PCRS to be cost-effective. As PCRS links HIV-infected partners to client-centered counseling and other interventions proven or likely to be effective, this appears to be a threshold relatively easy to achieve by programs. Greater effectiveness, such as preventing only 2-3 infections for every 51 HIV-infected partners reached through PCRS, would convey substantial cost savings to society.

1.4 Who Benefits from PCRS?

Clearly, three distinct beneficiaries of PCRS are (1) persons with HIV infection; (2) their spouses and other sex and/or needle-sharing partners; and (3) affected communities (Fenton and Peterman, 1997). Through a client-centered approach, HIV-infected persons can receive counseling about their risk behavior and be offered a range of choices and support in informing their partners of the possibilities of exposure to HIV (CDC, 1994). Studies have shown that a client-centered counseling approach can result in behavior change, thereby decreasing the likelihood of HIV transmission to others (Kamb *et al.*, 1998 and Fenton and Peterman, 1997). HIV-infected persons can also benefit from referrals to other social and medical services, such as couples counseling, prevention case management, and antiretroviral therapy.

For the partners of HIV-infected persons, one basic benefit comes from being informed that they are at risk. This will be particularly helpful information for those who do not even suspect that they might have been exposed. Once informed, the partner can decide to access available HIV prevention counseling and testing services. If not infected with HIV, partners can be assisted in changing their risk behavior, thus reducing the likelihood of acquiring the virus. Or, if already HIV-infected, the partner' s prognosis can be improved through earlier diagnosis and treatment.

The role of PCRS, earlier diagnosis, and prevention and treatment services might have prevention benefits at the community level in reducing future rates of HIV transmission. Evidence is accumulating that antiretroviral therapy reduces the amount of HIV in genital secretions and fluids and thus might reduce the infectivity of HIV (Gupta P, *et al.*, 1997; Vernazza PL, *et al.*, 1997; Vernazza PL, *et al.*, 1997; Musicco M, *et al.*, 1994). However, concern may be well justified that some might misinterpret antiretroviral therapy as a cure for HIV and thus be less concerned about adopting safe behaviors or exposing others (Kalichman SC, *et al.*, 1998; Kelly JA, *et al.*, 1998; Remien RH, *et al.*, 1998; Remien RH, *et al.*, 1998). Efforts to link HIV-infected persons to treatment must also continue to emphasize safe behavior during the course of treatment. Effective PCRS also can improve disease surveillance, identify social sexual networks at high risk that can then be targeted for prevention (Fenton and Peterman, 1997), and potentially assist a comprehensive program in lowering the transmission rate of HIV. In addition, PCRS can benefit service providers in the community by increasing their access to individuals in need of their services, especially people who would not come to them on their own.

1.5 What Activities Are Involved in PCRS?

PCRS should be introduced at the point an individual seeks HIV prevention counseling and testing. A brief overview of the activities associated with PCRS is included in this section, but more detailed discussions are provided throughout the remainder of this document.

- **Person Seeks HIV Prevention Counseling and Testing**. PCRS begins when persons seek, either through private care providers or publicly funded programs, HIV prevention counseling and testing. As they enter services, they should be assisted first, ideally through client-centered counseling techniques, in -
    1. assessing their risks of acquiring or transmitting HIV, and
    2. negotiating a realistic and incremental plan for reducing risk.

  During the initial counseling and testing session, the provider should also explain (1) how HIV testing will be conducted if the client does choose to be tested, and (2) all the available options for PCRS. The provider must assist clients in understanding their responsibility, if their HIV test results are positive, for ensuring that their partners are informed of their possible exposure, and referring those partners to HIV prevention counseling, testing, and other support services (CDC, 1994).
- **Client Tests Positive and Chooses To Participate in PCRS**. Once a client' s test results are confirmed positive, that person should be provided the earliest appropriate opportunity to receive partner counseling and referral services. Reactions to learning one is infected with HIV vary, and personal circumstances differ among individuals. PCRS providers need to recognize and accommodate those clients who need other issues resolved before being ready to participate in PCRS. This might mean, for some individuals, scheduling a follow-up appointment to discuss PCRS issues more thoroughly.
- **PCRS Provider and Client Together Formulate a Plan and Set Priorities.** The PCRS provider (who might not be the counseling and testing provider) counsels the client on if, how, and when specific partners should be informed of their risk of exposure. The provider should present partner referral options (Section 3.2). Then, the client and PCRS provider together can develop a plan for reaching partners that uses one or more of the referral options. The plan should be one that will result in each partner being (1) informed of possible exposure to HIV; (2) provided with accurate information about HIV transmission and prevention; (3) informed of benefits of knowing one' s serostatus; (4) assisted in accessing counseling, testing, and other support services; and (5) cautioned about the possible negative consequences of revealing their own or others' serostatus to anyone else. As the individualized plan is developed, the PCRS provider and client prioritize which partners should be reached first (Section 3.0 provides a discussion of how priorities are set).
- **HIV-Infected Client Voluntarily Discloses Information About Partners.** The HIV-infected client is encouraged to voluntarily and confidentially disclose the identifying, locating, and exposure information for each sex or needle-sharing partner that the PCRS provider or the client will attempt to inform.
- **Client and/or Provider Informs Each Partner of Possible Exposure to HIV.** The client and/or the PCRS provider inform each sex or needle-sharing partner who can be located of his or her possible exposure to HIV. Ideally, the partner is always informed confidentially face-to-face, but this cannot necessarily be ensured when the client chooses to inform the partner without the provider's assistance.
- **Client and/or Provider Assists Partner in Accessing Counseling, Testing, and other Support Services.** At the core of PCRS is referring the now-informed partner to counseling, testing, and needed social and medical services. If on-the-spot counseling and/or testing for HIV and other STDs is not practical or not desired at this time, each partner should receive, immediately upon being informed of possible exposure to HIV, a specific referral for obtaining client-centered counseling and testing. Some partners will also need immediate referrals for medical evaluation, substance abuse treatment, mental health, or other support services to enhance or sustain risk-reducing behaviors.

How each PCRS activity is conducted might have a direct impact on how communities perceive the value of such efforts to themselves and to public health. Quality assurance for services provided, routine staff and program evaluations, and network analysis are, therefore, necessary components of PCRS. For example, ensuring that strict confidentiality is maintained for all persons involved in PCRS will encourage community support and involvement. (See Sections 4.3, 4.5, and 6.2)

2.0 AVAILABILITY OF PCRS

2.1 Making Services Available to All HIV-infected Persons

People can learn that they are HIV-infected through a variety of sources, including confidential and anonymous testing sites, private care physicians, or home collection kits. However, regardless of where and how persons have been tested, PCRS must be made easily accessible to all HIV-infected persons. For example, an HIV-infected person who has been tested by a private provider might seek services from a CDC-funded provider. Although verified evidence of HIV infection should always be presented to the PCRS provider before partners are contacted, PCRS must be made available to the HIV-infected person.

The client who has just been informed of being HIV-infected will, of course, need to have PCRS offered at the earliest appropriate time, but the PCRS provider will encounter many others to whom services should be offered. For example, those persons could include a previously identified HIV-infected -

- client who in the past was not offered PCRS;
- sex or needle-sharing partner who the PCRS provider learns is continuing to have unprotected sex and who has partners other than the original HIV-infected client;
- client who now has new sex or needle-sharing partners;
- client who is now seeking additional STD or family planning services or substance abuse treatment; or
- client who in the past refused or only partially participated in PCRS but has now decided to participate fully.

Health department HIV prevention program staff should ensure that health care and prevention providers in the community and HIV-infected persons in the area are aware that PCRS is available at publicly funded sites and are aware of how to access those services. Furthermore, health departments can expand access to PCRS by developing agreements with private providers. These agreements could specify that the private providers will deliver PCRS to their HIV-infected clients. In such situations, these providers should be given relevant information, training, and support to successfully deliver the services.

STANDARD: All CDC-funded HIV prevention counseling and testing sites, both confidential and anonymous, must make PCRS available to all HIV-infected persons.

2.1.1 Services for Those Persons Tested Anonymously

Opportunities to access PCRS must be provided to HIV-infected clients who have been tested anonymously and choose to remain anonymous. Program experience has indicated that PCRS can be conducted in an anonymous setting (Hoffman, *et al.*, 1995). CDC requires that, unless prohibited by state law or regulation, grantees must provide reasonable opportunities for anonymous testing. Clients who test HIV-positive in anonymous settings must be counseled on how to enter a confidential system and be

strongly encouraged to do so. This will assist them in receiving medical care and other services, including PCRS.

Recent reports show that persons who enter anonymous HIV testing programs do so earlier in their HIV infection and are more likely to begin medical care while still comparatively well (Bindman *et al*., 1998; Nakashima *et al*., 1998). CDC currently recommends that persons initially testing positive for HIV in an anonymous setting be counseled and informed about how to enter a confidential medical care system.

STANDARD: CDC-funded programs must provide access to PCRS for persons testing anonymously without requiring that the infected client disclose his or her identity.

2.1.2 Inability to Pay

CDC-funded PCRS programs must provide access to PCRS regardless of clients' or partners' ability to pay (CDC, 1993).

2.2 Accommodating Requests from Other Health Jurisdictions

PCRS providers might sometimes be asked to contact the partner of an HIV-infected person residing in another health jurisdiction. Such contacts in other jurisdictions are the role of the state health department. For example, a PCRS provider might request that the staff in a neighboring state health department assist in locating and informing a previous partner or former spouse of an HIV-infected client. A reasonable effort must be made to accommodate that request if it complies with state and local regulations and policies, and confidentiality is maintained.

STANDARD: Requests for PCRS from other health jurisdictions must be accommodated whenever practical.

3.0 DECIDING ON A PCRS PLAN AND SETTING PRIORITIES

3.1 Encouraging Client Participation

3.1.1 Fully Informing and Reassuring Clients

The PCRS provider should explain the purpose and process of PCRS before PCRS activities can begin. The HIV-infected person serves as the "gate-keeper" to his or her partners. Program experience indicates that once a person understands the benefits both to themselves and their partners, they willingly participate in PCRS. Therefore, ensuring that the HIV-infected person fully understands the PCRS process and its benefits is important.

Providers should create an environment that is private, confidential, and comfortable enough so that clients are encouraged to participate in PCRS without feeling fearful or coerced. Reminders of the voluntary nature of PCRS and explanations of how privacy will be maintained for clients and partners alike will be necessary before some individuals feel secure enough to participate.

Each interaction a counseling and testing or health care provider has with an HIV-infected client is a potential opportunity to discuss the importance of informing that person' s sex or needle-sharing partners of their possible exposure to HIV. Prevention counseling, prevention case management, and medical follow-

up sessions while clients are in treatment, all provide opportunities to stress the importance of getting partners involved in PCRS. Community-level interventions provide other opportunities to reach out to partners.

> **STANDARD:** PCRS providers must ensure that clients are aware that all information disclosed by them will be kept strictly confidential and that participation is always voluntary.

3.1.2 Developing an Atmosphere of Trust

The success of the PCRS process hinges on the trust and cooperation of the persons infected with HIV and their partners. How well the provider fosters an atmosphere of trust, respect, and rapport with the HIV-infected individual will have a significant impact on PCRS. Client-centered counseling techniques (CDC, 1994) are highly recommended for developing this relationship, not only with original clients but also with their partners. The ability to develop trust and rapport will also enhance the PCRS provider' s effectiveness when working in the community.

> **STANDARD:** To foster an atmosphere of trust, PCRS providers must treat all HIVB-infected clients and their partners with respect.

3.1.3 Introducing PCRS

During the first visit, the health care provider, using a client-centered approach (CDC, 1994), should begin discussions with the client on the risks to his or her partners. This visit would typically be for HIV counseling and testing. When clients choose to be tested and the results are positive, then the provider must offer, at the earliest appropriate opportunity, to assist in formulating an individualized PCRS plan. That plan is always based on the personal circumstances of the HIV-infected client and each of his or her partners.

When the provider demonstrates genuine concern for the overall well-being of clients and their partners during discussions about PCRS, the provider encourages greater client participation. Clients' reactions vary significantly to learning that their HIV test results are positive; therefore, the provider must gauge the appropriate point at which to initiate the discussion about the PCRS plan. In fact, other critical issues might need to be resolved first. For example, the client might express suicidal ideation or a fear of a violent reaction from a partner. Because potentially violent situations might be encountered, collaboration between the PCRS program and the appropriate state or local violence prevention programs is important. Such collaboration will help in developing plans and protocols for such situations and provide opportunities for the PCRS provider to learn about relevant services.

> **STANDARD:** Persons entering CDC-funded prevention counseling and testing programs must be counseled at the earliest opportunity about PCRS and options for informing sex and needle-sharing partners of possible exposure to HIV.

3.2 Formulating a PCRS Plan

HIV prevention programs use two basic approaches for reaching partners (West and Stark, 1997). In this document, the term ***client referral*** is used when HIV-infected individuals choose to inform their partners themselves and refer those partners to counseling and testing (see Section 3.2.1). (NOTE: The terms ***patient referral*** and ***self-referral*** are sometimes used instead of ***client referral***.) The term ***provider***

referral is used in this document when the PCRS provider, with the consent of the HIV-infected client, takes the responsibility for contacting the partners and referring them to counseling, testing, and other support services (see Section 3.2.2).

Sometimes a combination of the two approaches is used. With the ***dual-referral*** approach, the HIV-infected client informs the partner of his/her serostatus in the presence of the PCRS provider. By having a professional counselor present, this approach supports the client and reduces other potential risks. In such situations the PCRS provider must not reveal the client' s serostatus to the partners without prior informed consent. With the ***contract-referral*** approach, the PCRS provider does the informing only if the client does not notify the partner within a negotiated time period (see Section 3.2.3).

The PCRS provider should explain to clients all available options for reaching their partners, including the advantages and disadvantages of each approach. Then, together they can formulate a plan that can result in each partner being confidentially informed and encouraged to access counseling and testing or other social or medical services. Some HIV-infected individuals will be reluctant to participate in PCRS. Client-centered counseling techniques and reassurances of confidentiality can encourage better participation. Resolving problems through role-playing, for example, might help clients overcome barriers to participating in PCRS and help them better prepare for their part in those activities. No matter which approach is chosen, the PCRS provider should ensure the partners are actually informed of the exposure.

STANDARD: The PCRS provider must explain to the HIV-infected client the options for serving partners and then assist that client in deciding on the best plan for reaching each partner confidentially and referring him or her to counseling, testing, and other support services.

3.2.1 Taking a Closer Look at Client Referral

When HIV-infected clients choose to inform their partners themselves, they usually need some assistance to succeed. Although the majority of clients do not experience negative consequences when notifying partners, the PCRS provider can help the client minimize any potentially negative consequences. The provider should, therefore, be prepared to assess the situation and ability of the HIV-infected client to make successful notification and referrals. Based on this information, clients might need to be coached on:

1. the best ways to inform each partner;
2. how to deal with the psychological and social impact of disclosing one' s HIV status to others;
3. how to respond to a partner' s reactions, including the possibility of personal violence directed toward the client or others; and
4. how and where each partner can access HIV prevention counseling and testing.

Despite the provider' s coaching, however, the client' s lack of counseling skills and experience might result in unsuccessful or ineffective PCRS. Another disadvantage of the client-referral approach is that the client might unintentionally convey incorrect information about HIV transmission, available support services, confidentiality protections, or other issues. The client also forfeits anonymity to partners, increasing the potential for disclosure of serostatus to third parties, subsequent discrimination, or partner repercussion. The findings of Landis *et al*. (1992) clearly indicate that fewer partners are actually informed of their possible exposure to HIV when the client-referral approach is used. However, because PCRS is a voluntary process, clients should be able to choose this approach. The PCRS program needs reasonable systems for monitoring whether partners are actually reached (see "Contract Referral" in Section 3.2.3). Also, more support to the client in notifying their partners will enhance the effectiveness of notifying partners.

For anonymous test sites, the client-referral approach poses a slightly different problem because some clients might be less likely to give the provider information about partners. Under these circumstances the provider will be less likely to determine whether PCRS has been successful. Although PCRS can be provided to anonymous clients, CDC currently recommends providers encourage the client to voluntarily enter a confidential setting for PCRS and additional medical follow-up. Here again, an appropriately detailed discussion with anonymous clients of how confidentiality will be maintained for themselves and their partners can ease the transition of anonymous clients to a confidential setting. That transition will also be eased if clients are not required to take another HIV test. If the anonymous and confidential test sites are at separate facilities, reciprocal agreements between the two might be necessary so that the client' s confirmed positive test result can easily be transferred to the confidential setting.

At confidential test sites, PCRS providers should make every reasonable effort to follow up with each HIV-infected client to assess how well he or she has progressed with PCRS. Whenever feasible, careful and confidential monitoring of which of the client' s partners actually do access counseling and testing services can greatly enhance quality assurance and program evaluation. This also will help ensure that partners have actually been reached.

Despite its drawbacks, client referral is the approach frequently chosen, and it can have some advantages. Because the client is usually more familiar with the identity and location of the partner, this approach can allow some partners to be referred for counseling and testing more promptly. Also, some clients choose this approach because they feel the best way to preserve a current relationship is by informing the partner themselves rather than having a third party - the provider - do it. Finally, when client referral is conducted successfully, fewer staff are used and fewer resources are consumed than with the provider-referral approach, so the financial burden for HIV prevention programs is reduced.

3.2.2 Taking a Closer Look at Provider Referral

When the client chooses provider referral, the provider will also need to assess the situation regarding each partner, including the best ways to inform them, how to locate and contact them, suggestions on how to approach them, how to predict the psychosocial impact of their learning their HIV serostatus, and how to respond to partners' reactions. Research indicates that provider referral is more effective in serving partners than client referral (Landis *et al.*, 1992). The following are some of the advantages of using the provider-referral approach:

1. The PCRS provider is able to readily verify that partners have been confidentially informed and have received client-centered counseling and testing services.
2. The PCRS provider can better ensure the HIV-infected client' s anonymity since no information about the client is disclosed to his or her partners.
3. A well-trained PCRS provider is better able to defuse the partner' s potential anger and blame reactions as well as accurately and more comprehensively respond to the partner' s questions and concerns.
4. Provider referral better facilitates learning about sexual and drug-injection networks, thus potentially enhancing overall HIV prevention efforts in affected communities.
5. In many cases, the PCRS provider can deliver on-site HIV testing to the partner.

Among the disadvantages of the provider-referral approach is the fact that PCRS providers are not always able to readily locate and identify the partners. Because the provider is less familiar with how to reach the partners, actually locating them to discuss their possible exposure to HIV can be more difficult. The provider-referral approach also entails substantial financial costs and causes some ethical concerns among leaders of affected communities (Fenton and Peterman, 1997; West and Stark, 1997). For example, Fenton and Peterman (1997) found that financial costs for provider referral are between $33 and $373 per partner notified and between $810 and $3,205 per infected partner notified. This program expense, however, is greatly offset in the long run because PCRS frequently reaches persons who do not suspect

they have been exposed to HIV and is likely cost-effective (see Section 1.3). Once informed, they can access prevention counseling and testing, and if HIV-infected, they can enter treatment earlier. It is important to note that some infected people who choose provider referral might still notify some partners about their serostatus and will thus need relevant counseling.

3.2.3 Taking a Closer Look at Combined Referral Approaches

Two variations on provider and client referral are the dual- and contract-referral approaches. Potentially, combinations of these approaches can enhance the advantages of both approaches for the client while reducing the disadvantages.

Dual Referral. Some HIV-infected clients feel that they and their partners would be best served by having both the client and the provider present when the partner is informed. The dual-referral approach can work well for these clients. The dual approach allows the client to receive direct support in the notification process. The PCRS provider is available to render immediate counseling, answer questions, address concerns, provide referrals to other services, and in some cases potentially minimize partner repercussions. Being present also enables the provider to know which partners have in fact been served, and to some extent, learn about sexual and drug-injecting networks. Whether the client or provider will take the lead in informing the partner should be worked out in advance of the notification.

The provider still needs to coach and support the client as with the client-referral approach. The provider and the HIV-infected client need to consider, in particular, the partner' s possible concerns about having his or her relationship with the client revealed to the provider. By considering this issue in advance, the client and the provider can anticipate the partner' s possible reactions and discuss how to respond appropriately.

Contract Referral. The other variation on provider and client referral, the contract-referral approach, might require more negotiation skill on the PCRS provider' s part. In the contract-referral approach, the provider and client decide on a time frame during which the client will contact and refer the partners. If the client is unable to complete the task within that agreed-upon time period, the PCRS provider then has the permission and information necessary to serve the partner. The provider must also have agreement with the client about how to confirm that partners were notified and what follow-up is required for situations where the client does not make the notification. Negotiation skill and a relationship of trust are needed so that the provider will have the identifying and locating information immediately available if the client does not inform the partner before the time limit expires.

When the contract-referral approach is used, the PCRS provider should also negotiate a provision with the client whereby the partner confirms in some way (e.g., telephone call, appointment for services) to the provider that he or she has been informed of being at risk. Otherwise, the provider may have difficulty knowing which partners have been informed and whether or not provider referral or some other assistance is now needed.

3.3 Setting Priorities for Reaching Partners

The PCRS plan must include prioritizing which sex or needle-sharing partners need to be reached first, based on each client' s and partner' s circumstances. Ideally, all partners should be reached, but limited program resources usually dictate that priorities have to be set. Priorities are determined by deciding (1) which partners are most likely to be already infected and to transmit infection to others; (2) which partners are most likely to become infected; and (3) which partners can be located. Priority is also affected by federal and state laws. For example, **federal legislation requires that a good-faith effort be made to notify "any individual who is the marriage partner of an HIV-infected patient, or who has been the marriage partner of that patient at any time within the 10-year period**

prior to the diagnosis of HIV infection." (Public Law 104-146, Section 8[a] of the Ryan White CARE Reauthorization Act of 1996.)

A number of factors influence how the PCRS provider and client decide which partners need to be reached first. Obviously, if the client has had only one partner during his or her life-time, that partner is likely to be infected. When the client has had more than one partner, other factors then have to be considered, such as the following:

- **Possible Transmission of HIV to Others.** The partner who is most likely to transmit HIV to others must receive highest priority. A partner who is a pregnant woman should be reached as soon as possible for counseling, testing, and referral to medical treatment if infected, to avoid perinatal transmission. Likewise, the partner who the client knows has multiple other sex and needle-sharing partners needs to be reached as soon as possible to reduce the potential for transmission of HIV to others.
- **Partners of a Recently Infected Client.** If, for example, the client had a negative HIV test result 6 months ago, but now the test result is positive, partners within that 6-month time period or in the potential "window period" that preceded the negative test would receive priority. These partners are more likely to have acquired or been exposed to HIV than any of the client' s partners during the period before the client's HIV negative test. Other evidence of a recently infected person might be indicated by the exposure history of the client, e.g., client with a history of negative test results, findings from less sensitive EIA or serologic testing algorithm for recent HIV seroconversion, or other evidence of recent infection.
- **Likelihood of the Partner Being Unaware of Exposure to HIV.** Some individuals are less likely than others to suspect a risk for HIV infection or to understand what being "at risk" means. For example, many heterosexual women might be less aware of their HIV risk and therefore less likely to access counseling, testing, or other prevention services without PCRS.
- **Partners at Continued Risk.** Reaching the client' s current, recurring, or recent partners is a high priority because those partners might be at continued risk of becoming infected with HIV, if not already infected.
- **History of Other STDs.** Either the client' s or partner' s history of other STD infections is an important factor in setting priorities. For example, if a partner was treated for another STD, that partner is more likely to also be infected with HIV and, additionally, more likely to transmit HIV to others. If the HIV-infected client has a recent history of other STD infection, then his or her sex partners are more likely to have been HIV-infected, especially those exposed during the STD infection (Wasserheit, 1992).
- **Transmission of Strains of HIV that are Resistant to Antiretroviral Therapies.** If information or evidence exists that the client is infected with a strain of HIV resistant to antiretroviral therapies, partners of this client would have high priority for PCRS services.

The PCRS provider and client should begin by noting current or recent partners and the details of their exposure. Next, working back in time, they should consider any other partners who need to be contacted. By briefly noting the circumstances for each partner and then moving quickly on to the next one, the provider will be better able to stimulate the client' s memory. Then, together, they can determine the priorities for reaching as many partners as program resources might permit. Because determining when a client was actually infected or the circumstances associated with individual partners is often difficult or impossible, some HIV prevention programs routinely attempt to locate and counsel all partners from a defined time period. This time period, often 1-2 years, frequently is based on availability of resources for PCRS. Programs with greater amounts of resources, those with lower morbidity, or those that give higher priority to PCRS frequently attempt to reach and counsel partners exposed over a longer time period.

Once the provider and client have established which partners are to be reached, they can begin discussing a plan for reaching these partners. For those partners the provider will be contacting, exact locating information, plus the dates, types, and frequency of exposure should be noted (See Section 4.2). During this phase, new information about partners might come to light that necessitates adjustments in the priorities previously established.

In addition to the factors listed previously, the PCRS provider must also consider federal legislation and relevant state laws that require a good-faith effort be made in notifying current spouses or persons who have been spouses of a known HIV-infected person during the 10 years prior to the client' s diagnosis of HIV infection. Both the program policies of PCRS and the efforts of individual providers contribute to the required good-faith effort.

PCRS providers can satisfy the requirement of a good-faith effort by (1) asking all HIV-infected clients if they have a current or past marriage partner(s), (2) notifying these partners of their possible exposure to HIV, except in situations when, in the judgment of public health officials, there has been no sexual exposure of a spouse to the known HIV-infected individual during the relevant time frame; (3) referring them to appropriate prevention services; and (4) documenting these efforts. Programs need to have or develop policies to guide providers in situations in which the HIV-infected client does not give consent and will not allow the provider to notify his or her current or past marriage partner(s).

STANDARD: The PCRS provider and HIV-infected client must prioritize reaching partners based on who is most likely to transmit infection to others and who is most likely to become infected.

3.4 Considering Other Options and Special Circumstances

3.4.1 Other Persons Who Might Need To Be Contacted

While the PCRS plan is being developed and priorities are being set for reaching partners, the provider should take special note of any other persons being mentioned who might be at risk. For example, during interviews or counseling sessions, the HIV-infected client might discuss other persons who are not sex partners but are involved in a sexual or drug-injection network with high risks of HIV transmission. Another example is children or newborns who might have been exposed perinatally or through breast-feeding. Although not direct sex or needle-sharing partners of the HIV-infected client, these other persons should be offered HIV prevention counseling and testing, if resources and program policies permit. General information obtained through PCRS, not just a person' s name, can be used to identify high-risk places and venues where PCRS programs can provide outreach services. CDC encourages such efforts to identify and lower risks of HIV and other STDs within sexual or drug-injection networks and is interested in working with state and local health authorities to develop methods and more detailed guidance on network identification, analysis, and intervention.

3.4.2 "But, I Do Not Want My Partner to Be Contacted!"

Unfortunately, in some cases HIV-infected clients initially will simply not want their partners notified. For example, they might fear loss of anonymity, the breakup of a relationship, or other adverse consequences. Clients might say that partners have already been informed about their risks or that partners would not be interested in counseling, testing, or other support services. Providers can encourage a client' s participation by explaining that the partner benefits by knowing his or her HIV status and being able to seek immediate treatment if infected. Also, if infected, the partner can avoid transmitting the virus to others. However, when a client is determined not to disclose partner names, the PCRS provider should counsel the client as if he or she has chosen the client-referral approach.

Sometimes a client might not want his or her partner notified because of fear of a violent reaction from the partner. It is not uncommon for persons receiving public health services to report having experienced violence in their lives (Maher, 1998). Therefore, providers should be aware of the potential for partner violence and should be prepared to make appropriate referrals. If the provider has indication of a potentially violent situation for the client or others, the provider must make an assessment prior to notifying the partner and seek expert consultation before proceeding. States have varying legal requirements about reporting situations such as those involving violence or child abuse. The PCRS program must comply with relevant state laws and local regulations.

In some cases, the provider knows of a partner at risk even though the client has not identified that partner. Whether or not a legal "duty to warn" such partners (or identified partners that the client did not want notified [see Appendix B]) exists is best determined by reviewing applicable state laws or regulations, especially regarding spousal notification. All states must have a policy established to guide health department staff in situations in which an HIV-infected client indicates he or she does not plan to notify known partners and will not provide the information necessary for the health department staff to make the notification.

The Association of State and Territorial Health Officials recommends in its 1988 *Guide to Public Health Practice: HIV Partner Notification Strategies* that a health care provider may invoke his or her "privilege to disclose" (see Appendix B) when that provider knows of an identifiable at-risk partner who has not been named by the HIV-infected person. State and local HIV prevention program managers should consider the ASTHO recommendations and their own relevant laws when developing policies and procedures.

STANDARD: CDC-funded PCRS providers must review with the HIV-infected client in appropriate detail the legal and ethical reasons for informing sex and needle-sharing partners of their possible exposure to HIV.

3.4.3 PCRS for Needle-sharing Partners

Sharing of needles, syringes, and other paraphernalia used for injection drug use (e.g., illicit drugs, steroids) carries high risk for transmission of HIV. Throughout this document, the importance of providing partner counseling and referral services to HIV-infected clients with needle-sharing partners is emphasized. CDC recognizes that some HIV prevention programs have relatively limited experience in working with needle-sharing partners and that special issues exist relating to clients disclosing information about such partners, reaching such partners, deciding which prevention interventions should be provided, and referring them for needed services.

Some state and local HIV prevention programs have already gained considerable experience in reaching and serving needle-sharing partners and report that such services are feasible and likely to be effective. For example, Levy and Fox (1998) reported that injection drug users infected with HIV want to notify their sex and needle-sharing partners and are willing to participate in the PCRS process. Information provided by HIV-infected clients who are injection drug users may help HIV prevention program managers gain insight into the extent and types of prevention service needs of injection drug users and how best to deliver and target such services.

CDC will provide expanded guidance on PCRS for needle-sharing partners in future versions of this guidance.

4.0 LOCATING AND NOTIFYING PARTNERS

4.1 Preparing the PCRS Provider

In large part, the manner in which PCRS is provided to and perceived by the affected communities determines how successful HIV prevention programs will be (see Section 4.5). Therefore, program managers and supervisors should ensure that PCRS staff -

- are skilled and competent in providing PCRS;
- are culturally competent and demonstrate respect for the community to be served;
- are knowledgeable about HIV infection, transmission, and treatment;
- are knowledgeable in local, state, and federal laws regarding HIV and other relevant issues of providing health care, especially the right to privacy and confidentiality;
- receive updated information and periodic retraining as appropriate;
- have standards, objectives, and specific guidelines for performance;
- are appropriately supervised and given written and oral feedback about their performance on a regular basis; and
- have appropriate problem-solving skills to deal with situations that might be encountered in a field setting, e.g., personal safety, violence to others.

In addition to receiving formal training, such as CDC' s training course on PCRS, an inexperienced PCRS provider should complete an internship by being teamed with a more experienced provider for a period of time before conducting PCRS alone (see Section 6.1). Another way to enhance a provider' s performance is through routine peer review of selected cases.

Providers of successful PCRS programs regularly go outside the clinic or office setting to reach partners. The inexperienced provider will need training in deciding when to deliver PCRS outside the office or clinic and when to postpone PCRS. Benefits of delivering PCRS in a partner' s home might include providing the partner with a familiar environment and helping the provider better understand the personal circumstances of that partner. Whether or not to do PCRS outside the clinic or office, or whether it is best postponed until an adverse situation can be resolved, must be decided on a case-by-case basis. In addition, training in avoiding confrontations, diffusing anger, and mediating disputes will better prepare any provider for handling potentially violent situations.

STANDARD: Program managers and supervisors must ensure that each PCRS provider has the appropriate training and skills to effectively serve HIV-infected clients and their partners.

4.2 Setting Activities in Motion

For those partners the provider will be contacting, the first step the provider should take is to verify the identifying and locating information given by the HIV-infected client. Locating and notifying partners should begin as soon as possible after the provider and HIV-infected client have decided on the best approach to use for each partner and priorities have been set for reaching partners. If the client will be informing partners, the client should be well-coached on how to do so and should be provided opportunities to obtain additional counseling, assistance, or other support during the process.

STANDARD: Locating and notifying activities must begin promptly once the PCRS plan has been formulated and the priorities set for reaching partners.

4.3 Maintaining Confidentiality

Confidentiality for all persons involved in PCRS must continue to be maintained. All attempts to make contact with a sex or needle-sharing partner should be confidential. This is often difficult because other community members might ask the purpose of the provider' s visit and why he or she is attempting to make contact. Nevertheless, providers should not, for example, reveal to others why they are trying to find a particular person. Likewise, providers should never leave a note or message that mentions HIV exposure as the reason for attempting to make contact. In addition, no other information should be revealed that might lead to others learning the reason for the contact or that might otherwise lead to disclosure of sensitive information or to a breach of confidentiality. As each partner is located, he or she should be informed privately and face-to-face, if at all possible. However, if the person refuses to meet with the provider, informing a partner by telephone might become necessary. In such situations, only limited information should be provided to the partner, and the goal still should be to arrange a face-to-face meeting if at all possible. Informing a partner by telephone should only be done as determined by state and local jurisdictions and after every step has been taken to ensure that the correct person has been located, is on the telephone, and others are not listening. Further attempts should be made to arrange a meeting in person.

The original HIV-infected client will sometimes inquire about the results of the PCRS provider' s activities regarding his or her partners. The provider, when requested, can reveal whether a particular partner has been informed of his or her exposure to HIV, but must not reveal any confidential information about that partner, including whether the partner decided to be tested or whether he or she is HIV-infected.

Of equal importance is not revealing any identifying information about the original client to the partner, including the person' s sex, name or physical description, or time, type, or frequency of exposure. Although the PCRS provider will need to document the results of his or her activities in a thorough, concise, and timely manner, confidentiality must still be maintained for all persons involved. Information that identifies partners should be kept locked in a secure location. Client and partner information, other than the official record (as determined by state practice), should be destroyed when current PCRS activities are concluded.

State or local areas should establish PCRS record-keeping policies and procedures, and client and partner information should be maintained in accordance with these policies. Many public health programs have developed policies and procedures to safeguard sensitive client or partner information. One example can be found in CDC's *Guidelines for HIV/ AIDS Surveillance*, Appendix C, Security and Confidentiality (as revised October 1998). In developing their policies, PCRS managers can choose to review and adapt the policies and procedures in this document or those of other public health programs.

STANDARD: While conducting PCRS activities in the community, providers must continue to maintain confidentiality for all HIV-infected clients and their partners.

4.4 Helping Partners Access Services

The PCRS provider must be well prepared to handle the initial reactions of the person who is being informed of possible exposure to HIV. That person will undoubtedly need immediate counseling, followed by referral to additional HIV prevention counseling. The provider must be prepared to answer the questions and concerns of each partner without revealing any identifying information about the original HIV-infected client.

As described earlier, referring partners to needed prevention, treatment, and other relevant services is a goal of PCRS. Testing is a very important issue to persons who have just learned of possible exposure. The provider must be prepared, at a minimum, to refer them to counseling and testing services. For many years, providers have taken blood specimens of those who consent at the time of notification, which requires specialized training. With the current availability of oral fluid and urine collection kits, and rapid testing systems, program managers are encouraged to consider providing on-the-spot collection of specimens for

HIV testing as each partner is informed. If the partner has previously been tested, and those results were negative, the PCRS provider should stress the need to follow up with another test if exposure history indicates it is warranted.

However, many partners will need referrals for other kinds of social and medical support services beyond counseling and testing. The PCRS provider should already have agreements in place and an up-to-date resource guide so that immediate referrals can be made to services such as substance abuse treatment, family planning assistance, other STD treatment, domestic violence prevention, mental health counseling, or housing assistance (CDC, 1993). Having agreements in place for collaboration between PCRS providers and referral sources will help ensure that those services can be successfully accessed. PCRS providers should then follow up with each partner contacted to ensure that test results and other referral services have in fact been received. If providers in another health jurisdiction have been asked to contact a partner, health departments should follow up with that provider to determine that services have been received.

STANDARD: As each partner is informed of possible exposure to HIV, the PCRS provider must be prepared to assist that person with immediate counseling and referrals for more intensive counseling as well as testing and other support.

4.5 Addressing Community Concerns

The potential exists for PCRS to have a negative impact on HIV-infected individuals, their partners, or affected communities (Rothenberg and Paskey, 1995; West and Stark, 1997). Some community leaders view these kinds of activities with suspicion and are apprehensive about such issues as -

- whether disclosure of partner names is done voluntarily;
- possible denial of health care or other services if the HIV-infected client refuses to reveal partner names or otherwise refuses to cooperate with the provider;
- unintended effects on personal relationships, such as partnership breakup or violence;
- potential for invasion of privacy or loss of confidentiality for HIV-infected clients and their partners; and
- possible discrimination if confidential information held by government agencies is ever released, either accidentally or by law.

Although PCRS providers cannot always resolve these issues, they can strive to build relationships of trust between themselves and those they serve, including the leaders of affected communities. Working with HIV prevention community planning groups and others when determining and evaluating priorities, policies, and procedures for PCRS will help increase community support and acceptance. PCRS providers should be prepared, whenever an opportunity arises, to address legitimate concerns and dispel misconceptions about policies and practices (West and Stark, 1997).

5.0 COLLECTING, ANALYZING, AND USING PCRS DATA

5.1 Why Collect Program Data?

PCRS data must be collected and used (1) to assess the behavioral risks for sex and needle-sharing partners of HIV-infected persons; (2) to evaluate the effectiveness of the PCRS program as part of the overall HIV prevention effort; and (3) to improve how other HIV prevention activities, interventions, and services are implemented.

Accurate and consistent data collection is a critical component for evaluating how effective the PCRS program is, as well as how well it enhances the overall HIV prevention intervention (CDC, 1994).

Moreover, PCRS data enable providers to better focus prevention efforts on those persons most at risk. When the data reveal information about networks of people who are having sex or injecting drugs, the dynamics of HIV transmission can be better analyzed (Fenton and Peterman, 1997), and more intensive prevention and education efforts can be applied for specific high-risk groups (West and Stark, 1997). To do all this, however, the collected data must be relevant to behavioral risks, HIV/AIDS prevalence, and the demographics of affected communities. With accurate and consistent data, the staff of health departments and community-based organizations and members of HIV prevention community planning groups can establish an effective mix of prevention strategies.

5.2 What Data Should Be Collected?

Any data collection tool used in a PCRS program should be designed so that certain core information can be ascertained, including answers to the following:

- What proportion of HIV-infected clients is offered PCRS?
- What are the reasons those clients either reject or accept PCRS?
- What is the range of PCRS services (e.g., client referral, provider referral, combinations of referral approaches) offered to and accepted by each client?
- How many sex or needle-sharing partners are identified?
- What is the percentage of partners actually reached through PCRS, and how many of those partners are HIV-infected? Of those partners who are HIV-infected, how many are being informed of their infection for the first time?
- What are the demographics (e.g., marital status, age, sex, race/ethnicity) of the clients and partners actually served?
- How many partners are offered referral services? How many receive these services? In what time frame do they receive referral services?

And, perhaps most importantly, PCRS program managers should routinely assess what all of this information means in regard to how well PCRS is working for HIV-infected clients, their partners, and the community at large. Are clients served well? Are partners gaining access to services that might not be otherwise available? Are communities becoming more supportive of public health efforts? Does evidence exist that risks are being reduced? Are other prevention program services better targeted to communities in need?

The HIV prevention program managers in each health jurisdiction should decide how best to collect, analyze, and use PCRS data. This should be done in a manner that is consistent with the policies and procedures that they have developed to safeguard the security of the data and the confidentiality of the client or partner (see Section 4.3). Those managers should keep in mind that misconceptions about the collection and use of HIV data, in addition to a general mistrust of publicly funded agencies, are two of the biggest barriers to HIV prevention efforts in affected communities. CDC plans to work with state and local HIV prevention and STD prevention and treatment programs to develop proposals for standardizing the collection and analysis of PCRS data.

STANDARD: CDC-funded PCRS providers must collect data that help answer questions about how well the PCRS program is functioning; the extent and quality of services being provided; the degree to which clients and their partners accept and are satisfied with services; and how PCRS and other prevention services can be enhanced.

STANDARD: CDC-funded PCRS providers must use standardized data collection tools

throughout the program that maintain the privacy or confidentiality of the original HIV-infected client and his or her partners.

6.0 ENSURING THE QUALITY OF PCRS

6.1 Training

Of all the resources necessary for the successful operation of PCRS programs, training is perhaps the most critical (Fenton and Peterman, 1997). Each individual PCRS provider must receive initial basic training plus periodic updates on how to conduct PCRS (including its scientific rationale), provide client-centered counseling, protect individuals' rights to privacy, use scientific information in prioritizing partners, administer HIV tests when appropriate, and defuse potentially violent situations involving clients, partners or staff (see Section 4.1). PCRS providers also need to understand laws regarding confidentiality of medical records.

STANDARD: PCRS providers must be well trained to provide effective PCRS services.

6.2 Quality Assurance and Evaluation

Quality assurance for PCRS programs entails ensuring that appropriate and standardized methods are used for -

1. counseling HIV-infected clients regarding the notification of their partners;
2. developing a PCRS plan with HIV-infected clients;
3. prioritizing which partners are to be reached;
4. locating and informing those partners of their possible exposure to HIV;
5. providing immediate counseling and testing services to informed partners and/or referring them to other service providers; and
6. collecting, analyzing, using, and storing PCRS data.

Written job descriptions, including minimum performance criteria, and comprehensive procedures for delivering quality PCRS should be developed and copies made available to all personnel. Also, supervisors should directly observe a new PCRS provider until confident that the provider is proficient in serving clients and their partners. Then, through periodic supervisor observation, peer review of selected cases, and "customer" satisfaction surveys, each PCRS provider should be given constructive oral and written feedback.

PCRS programs should include policies relevant to situations in which an HIV-infected person knowingly exposes others to HIV. These policies must comply with relevant state or local laws.

The overall program should also be regularly evaluated to determine the quality of effort and the success in reaching the PCRS goals (Fenton and Peterman, 1997) (see Section 1.2). Program evaluations should include a comprehensive assessment of all confidentiality procedures that includes, at a minimum, record-keeping.

STANDARD: CDC-funded PCRS programs must have a quality assurance plan.

STANDARD: CDC-funded PCRS programs must evaluate their services.

6.3 How Can CDC Help?

Many types of technical assistance are available for designing, managing, or evaluating PCRS through CDC' s project officers, program consultants, and network of HIV prevention partners. In addition, training is provided through CDC and its contractors that is designed to enhance PCRS providers' skills regardless of their level of experience. Finally, information on the latest scientific findings about HIV is available through the CDC National Prevention Information Network (toll-free, 800-458-5231).

Health Communications / Public Information (HC/PI)

Health Communications/ Public Information is the delivery of HIV prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Health communications and public information can be delivered using the following means:

Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience.

Print Media: These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.

Hotline: Telephone service (local or toll-free) offering up-to-date information on HIV/AIDS and referral to local services, e.g., counseling/testing and support groups.

Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide information to the general public as well as high-risk populations.

Presentations/Lectures: These are information-only activities conducted in group settings; often called "one-shot" education interventions. Workshops and presentations are typical activities of community outreach. Because they usually follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. While they supply important opportunities to disseminate HIV/AIDS prevention information, their impact on behavior change is limited because they are usually single-encounter experiences. Although they provide crucial information that raises awareness and increases knowledge and may be a critical first step in the change process, the information alone is usually inadequate to sustain behavior change.

One example of this type of activity is **Community Workshops and Presentations**, which are one-shot activities in which participants are provided with basic information on HIV/AIDS.

Standards for Community Workshops and Presentations

In a workshop or presentation, audience participation is to be strongly encouraged. Time must be allotted, usually at the end of the presentation, for a question and answer session. However, some questions may be so pressing, or some participants so persistent, that the presenter will have to address some questions and concerns during the presentation. Elements for a successful Community Outreach presentation include:

1. Speakers who are members of the target population of the audience.
2. A comprehensive workshop/presentation curriculum.
3. Assurance that curricula provide for discussion of related issues.
4. Detailed workshop/presentation outlines.
5. Methods to assure that the audience is informed about workshop/ presentation goals and objectives and that discussion of subject matter is facilitated.
6. Descriptions of skills-building exercises relevant to the program's objectives.
7. Referrals to agencies, hotlines and community information resources.

CDC Guidelines for Workshops and Presentations

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Workshops and presentations are typical activities of community outreach. Because they usually follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. While they supply important opportunities to disseminate HIV/AIDS prevention information, their impact on behavior change is limited because they are usually single-encounter experiences. Although they provide crucial technical information that raises awareness and increases knowledge and may be a critical first step in the change process, the information alone is usually inadequate to sustain behavior change.

To maximize their benefit, workshops and presentations should be planned carefully with knowledge goals and objectives specified before the individual sessions. To the extent possible, presenters should be informed about the setting where the workshop or presentation will take place, as well as the composition and knowledge level of the anticipated audience. The following are examples of issues the presenter might consider before conducting a presentation or workshop:

- Where will the workshop or presentation be held?
- What is the age range of the participants/audience?
- What is the language(s) of the participants/audience?
- What audiovisual equipment is available?

A well-planned, detailed outline, which allows flexibility, can prove useful and beneficial to the presenter and the participants/audience. Such an outline helps keep the presentation on track and focused. If a pretest evaluation is to be used, an outline can ensure that all relevant material will be covered in the lecture.

In a workshop or presentation, audience participation is to be strongly encouraged. Time must be allotted, usually at the end of the presentation, for a question and answer session. However, some questions may be so pressing, or some participants so persistent, that the presenter will have to address some questions and concerns during the presentation. The presenter should answer the questions succinctly and return to the original order of the presentation.

To increase the number of workshops and presentations they are able to provide, some agencies will elect to develop speaker's bureaus to augment their paid staff. Recruitment, training, and retention of volunteers present complex programmatic questions and are not to be undertaken lightly. Several references related to volunteers are provided at the end of this document and should be reviewed carefully.

A more detailed list of important points to consider for workshops and presentations is contained in Appendix C. The points below are relevant to agencies providing workshops and presentations either by paid staff or by volunteers in a speaker's bureaus. Effective presenters:

- Possess organizational and public speaking skills.
- Are well informed and comfortable talking about the subject.
- Ensure that the presentation is linguistically appropriate for the audience.
- Elicit and encourage audience participation.
- Are adaptable to logistics and audience needs.
- Are non-judgmental.
- Assess the nature of questions to make appropriate responses, i.e., whether better answered in private.
- Seek accurate answers to difficult questions and provide information in a timely manner.

A few items specifically needed in a Community Outreach Program Plan are listed below.

- A comprehensive workshop/presentation curriculum.
- Assurance that curricula provide for discussion of related issues.
- Detailed workshop/presentation outlines.
- Logistical guidance for workshops/presentations (e.g., time and location, room arrangement, number of participants, number of facilitators).
- Methods to assure that the audience is informed about workshop/ presentation goals and objectives and that discussion of subject matter is facilitated.
- Descriptions of skills-building exercises relevant to stated program objectives.
- Training in the operation of audiovisual equipment and the use of diverse forms of audiovisual equipment.
- Recruitment of staff with organizational and public speaking skills.

Public Information

Standards for Effective Public Information Programs

- Public information activities must support other components of health education and risk reduction activities.
- Target audiences for public information activities must be selected, based on needs identified through the community needs assessment.
- Objectives for public information must be based on a realistic assessment of what communications can be expected to contribute to prevention.
- Messages must be based on the target audience's values, needs, and interests.
- Messages and materials must be pretested with the target audience to assure understanding and relevance to their needs and interests.
- Community representatives must be involved in planning and developing public information activities to ensure community "buy in."

CDC Guidelines for Public Information

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

The Role of Public Information in HIV/AIDS Prevention

Public information activities alone do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts.

As defined here, the purposes of public information programs are to:

- Build general support for safe behavior.
- Support personal risk reduction.
- Inform persons at risk about infection and how to obtain specific services.
- Encourage volunteerism.
- Decrease prejudice against persons with HIV disease.

Public information programs craft and deliver data-driven and consumer-based messages and strategies to target audiences.

The public information program standards and guidelines set forth here are based on CDC's standards for health communication.

Definitions

CDC defines health communication as a "multidisciplinary, theory-based practice designed to influence the knowledge, attitudes, beliefs, and behaviors of individuals and communities" (Roper, 1993). Sound

health communication practice is based on a combination of behavioral and communication sciences, health education, and social marketing. Current practice extends beyond information dissemination to include a variety of proactive strategies addressing both individual and societal change.

A communication (public information) program is the delivery of planned messages through one or more channels to target audiences through the use of materials.

Successful public information programs share a number of basic characteristics, which include:

- A person in charge who manages the program well.
- Activities planned to fit what the community and target audience need and want.
- A variety of activities, including mass media, that can be directed over a period of time to the target audience.
- A measurable program objective or purpose.
- A commitment to evaluation -- tracking and measuring progress toward objectives.
- A time schedule.
- Efficient use of people and other resources.
- Well-planned and well-executed health communication in public information programs can accomplish the following:
- Raise awareness.
- Increase knowledge.
- Refute myths and misconceptions.
- Influence attitudes and social norms.
- Reinforce knowledge, attitudes, and behaviors.
- Suggest and enable action.
- Show the benefits of a behavior.
- Increase support and/or demand for services.
- Help coalesce organizational relationships.

Public information programs should use multiple approaches to motivate and involve people and communities. Using health communication methodologies, however, is not sufficient to guarantee change. Plans for creating sustained behavior change should include information/communications in combination with other prevention strategies. In this way, effective communications can significantly enable and contribute to change. For example, public information programs funded by CDC carry out parts of CDC's overall HIV prevention strategy. Consumer-influenced messages and strategies are best achieved by a systematic approach involving research, planning, implementation, evaluation, and feedback. The purpose of this section is to offer guidelines for conducting public information programs that have been developed as integral parts of an overall HIV-prevention strategy.

In addition to planning, pretesting, and evaluating public information strategies, specific components of public information programs -- producing educational materials, working with the print and broadcast media, hotlines, and special events -- are addressed here.

Planning for Public Information

To be effective, public information programs must be consistent with and supportive of broader programmatic objectives (e.g., to inform target audiences about and motivate them to use existing HIV counseling and testing services). Therefore, public information plans should be developed as one component of the comprehensive HIV prevention plan.

During the planning process, a number of key questions should be asked. The answers, which should be derived from targeted needs assessment data, will help to assure that public information efforts will support the HIV/AIDS prevention program objectives. These questions cover the following issues:

- What are the media preferences and habits of the target audience? What information sources (such as social networks, churches/religious institutions, coaches) do they consider credible?
- What are the media and other organizations that provide information in the targeted area? Which activities are related to public information? What are the specific audiences?
- What prevention program goals and objectives can public information support (e.g., increased knowledge, change in attitudes, motivation to act, increased skills, other behaviors)?
- What services/program activities should be promoted?
- What measurable objectives can be established? How can progress be tracked?
- What are the broad message concepts for the target audience? What should they be told? What do they want to know? Who will they believe and trust?
- What communication channels are most appropriate for reaching target audiences (e.g., radio, TV, print media, worksite, face-to-face, voluntary organizations, or the health care sector)?
- What materials formats will best suit these channels and messages? Are there any existing materials that can be used or adapted?
- How can the resources be used most effectively and for what combination of activities?
- In addition to answering these key questions, an important part of the planning process is determining the short- and long-term objectives of the public information program. Objectives could include the following:
- Increase the number of persons (target audience) calling a hotline or requesting information/expressing an interest in other ways.
- Increase the number of program participants, volunteers, requests for activities within a community.
- Increase beliefs among community leaders that support for HIV/AIDS issues is important.
- Increase the numbers of partner, family, or other discussions about HIV/AIDS.
- A comprehensive program could include all of these objectives. Most communities may find that they can take on one or two objectives at a time, then add to or alter their program focus as the program develops or community needs change.

Staff Training in Planning for Public Information

Staff working in public information programs should review, discuss, and receive training based upon the CDC health communication framework or a similar planning model such as that found in Making Health Communication Programs Work: A Planner's Guide. (National Institutes of Health. NIH Publication No. 89-1493. Bethesda, MD: U.S. Department of Health and Human Services, 1989.)

Staff should also be familiar with methods for tracking and evaluating public information activities.

Channel Selection

Communication channels are the routes or methods chosen to reach the target audiences. Types of channels include mass media, interpersonal transactions, and community-based interactions. Understanding the advantages and disadvantages of communication channels can help assure the best use of each,

including the coordination of mass media activities with other strategies where beneficial. Each channel has its own characteristics and advantages and disadvantages, as listed here:

MASS MEDIA (radio, television, newspapers, magazines)

Advantages:

- can reach many people quickly
- can provide information
- can help change and reinforce attitudes
- can prompt an immediate action (e.g., calling toll-free
- number)
- can demonstrate the desired action

Disadvantages:

- are less personal and intimate
- are less trusted by some people
- do not permit interaction
- offer limited time and space
- offer limited opportunities to communicate complex
- or controversial information alone, usually cannot
- change behavior
- can be costly

COMMUNITY CHANNELS (schools, employers, community meetings and organizations, churches/religious institutions, special events)

Advantages:

- may be familiar, trusted, and influential
- may be more likely than media alone to
- motivate/support behavior change
- can reach groups of people at once
- can sometimes be inexpensive
- can offer shared experiences

Disadvantages:

- can sometimes be costly
- can be time consuming
- may not provide personalized attention

INTERPERSONAL CHANNELS (e.g., hotline counselors, parents, health care providers, clergy, educators)

Advantages:

- can be credible
- can permit two-way discussion

- can be motivational, influential, supportive

Disadvantages:

- can be expensive
- can be time consuming
- can have limited target audience reach

Selecting the Appropriate Channel

The appropriate channel or channels for a specific project can be selected by assessing whether the channel is:

- Likely to reach a significant portion of the target audience. (Local media outlets can provide a demographic profile of their viewers/ readers/listeners.)
- Likely to reach them often enough to provide adequate exposure for the message/program.
- Credible for the target audience.
- Appropriate and accessible for the selected HIV/AIDS message.
- Appropriate for the program purpose (e.g., provide new information versus motivate action).
- Feasible, given available resources.

Choosing multiple channels can help combine the best traits of each and reinforce the message through repetition. For example, a major daily newspaper may reach the most people. Adding stories in a local African American newspaper may provide credibility within that community, and publicizing the hotline in these stories can help the reader get more information tailored to his or her needs.

Educational Materials

Educational materials are learning or teaching aids. They can be used to reach masses of people, to reinforce or illustrate information given in a one-on-one setting, or serve as references to remind people of information they received earlier. Materials also teach skills by providing hands-on experience or by illustrating a step-by-step approach. Effective materials can also influence attitudes and perceptions.

Development or selection of educational materials is directed by several considerations:

- What is the public information objective? Is it to inform, demonstrate, persuade, or remind? These considerations determine how educational materials are designed and used.
- Who is the target audience? Where (which channels) can they be reached? Are there any target audience preferences for types of materials (e.g., non-print for low-literacy audiences, fotonovelas for Latinas)?
- What is the specific message? Is it a skill, an attitude to be considered, medical information, a negotiation approach, or a synopsis of previous instruction?
- What materials are already available? Will they fit the audience, channel, and objective? Can they be purchased? Reproduced? Modified?
- What financial, staff, and other resources are available for materials development? Should development be handled in-house or by contract?

Choose Formats for Education/Information Materials

In selecting formats for educational and informational materials, choice should be guided by the amount and type of information to be presented, the channels to be used, and target audience preferences.

For most messages, using as many different formats as appropriate will provide more options for message promotion. Commonly used formats include:

Channel: Television

Formats: Public service announcements, paid advertisements, editorials, news releases, background or question and answer (Q and A) for public affairs programs

Channel: Radio

Formats: Live announcer copy (PSAs), taped PSAs, topic ideas for call-in shows

Channel: Newspaper

Formats: News releases, editorials, and letters to the editor

Channel: Outdoor
Formats: Transit ads, various sizes
Billboards, various sizes
Ads/posters for bus stop enclosures, airports

Channel: Community

Formats: Posters for beauty and barber shops, pharmacies, grocery stores, worksites
Bill inserts: shopping bag inserts or imprints, paycheck inserts Special event giveaways: calendars, fact cards, pencils, balloons, key chains
Table top or other displays for health fairs, waiting rooms, libraries, schools
Newsletter articles for community, employer, business newsletters Fotonovelas, flyers, pamphlets, coloring books for distribution through community settings

Channel: Interpersonal

Formats: Posters for physicians' offices and clinic waiting and examination rooms
Talking points, note pads for patient counseling, presentations at schools, organizations, religious institutions
Videos for classroom use

Review Available Materials

Before developing new materials, make sure that new production is necessary. If materials are available that will meet identified program needs, expense and effort can be saved. Contact the CDC National AIDS Clearinghouse (1-800-458-5231) to find out what is available.

Determine whether appropriate materials can be used or modified:

- Is the organization willing to share its materials? (Note: Virtually all materials produced by the Federal government are in the public domain. This means that they are not copyrighted and can be freely reproduced.)
- Can your program identity be substituted or added to the materials? (Make changes to fit planned public information activities.)
- Is the material available in the quantities needed? Is it affordable?
- Were the materials tested? With what results?
- How are the materials currently being used? By whom? With what effects?
- Are the materials suitable for the identified target audience and your community? (Testing may be needed to find out.)
- Are the messages consistent with specified public information and prevention program objectives?

Pretest Messages and Materials

Pretesting is defined as the testing of planned public information strategies, messages, or materials before completion and release to help assure effectiveness.

Pretesting is used to help make sure that messages and materials will work. It is important to test messages and draft materials with target audiences. Also, testing with media or other "gatekeepers" is a good idea, e.g., PSA directors or others who can influence whether messages and materials are used.

Pretesting can help determine whether messages and materials are:

- Understandable.
- Relevant.
- Attention-getting.
- Memorable.
- Appealing.
- Credible.
- Acceptable to the target audience.

These factors can make a difference in whether messages or materials contribute to meeting public information objectives.

The most frequently used pretest methods include:

- Focus groups.
- Self-administered questionnaires.
- Central location intercept interviews.
- Individual interviews.
- Theater-style testing.
- Readability testing.
- Gatekeeper review.

Specific pretest methods will vary, depending upon:

- Materials format(s).
- Complexity of the materials or messages (e.g., for complex messages, more time may be needed to explore audience reactions).
- Degree of sensitivity or controversy (e.g., a combination of methods helps make sure that responses are honest).
- Previous experience with or knowledge of the target group (i.e., less testing, or less in-depth exploration may be called for if a great deal is already known about audience views).
- Resources.
- The pretest questions to be explored.

Note: Additional information about pretesting can be found in Making Health Communication Programs Work: A Planner's Guide. (See Resources and References.)

Staff Characteristics for Materials Development and Pretesting

Staff who are involved in the development of educational materials should know the attributes and limitations of the educational materials formats to be used. In addition, they should:

- Speak, read, and write the language or dialect of the designated audience or have access to someone who does.
- Have the ability to identify accurately and incorporate appropriate literacy levels in design of materials.
- Communicate effectively in print and audiovisual media, or have access to competent materials producers.
- Be familiar with characteristics and life styles of designated audience.
- Be non-judgmental.
- Know the message and materials objective.
- Be able to personalize the material's message to be relevant to the target audience.
- Be able to design and conduct message and materials pretests or have access to trained and experienced help.
- Be able to design and implement distribution and promotion plans to assure appropriate use of materials to support public information activities.

Training for staff materials development and pretesting should:

- Emphasize how to design objectives, messages, and educational material.
- Instruct how to design and implement dissemination, promotion, and evaluation plans to assure appropriate use of materials.
- Inform about sources of additional information and related services.
- Teach how to determine appropriate motivator of behavior change.
- Instruct how to design and conduct pretests, including how to conduct focus groups.
- Provide practice sessions and opportunities for observation before conducting target audience pretests.
- Provide other training as needed (e.g., cultural sensitivity, low literacy materials development, sexuality attitudes, interviewing skills).

Using the Mass Media Effectively

The mass media is a vast and powerful sector of our society that includes television, radio, newspapers, magazines, other mass circulation print vehicles, and outdoor advertising. For HIV/AIDS prevention public information outreach, this category also can include shoppers' weeklies, newsletters published by businesses, periodicals distributed by organizations, newsletters from major employers, school/college newspapers, closed circuit television, and broadcast radio stations.

Opportunities for Messages in the Mass Media

The media offer more than news and public service announcements:

Beyond "hard" news, consider "soft" news that you help create:

- an upcoming activity;
- an event;
- findings from a public opinion poll or survey;
- a local angle to a national story;
- news appropriate for health or community features; and

- community advocacy of an issue that creates news.

For entertainment, consider:

- features in print or on television;
- talk and call-in shows;
- health and advice columns;
- consumers' own stories; and
- interviews with local personalities.

In addition to news or public service announcements for television and radio, ask for the following:

- businesses to sponsor paid advertisements or add an HIV prevention message to their ads;
- stations to include reminders as parts of station breaks;
- broadcast associations to help negotiate better rates for paid ads;
- the media to help in producing PSAs or video segments;
- consideration before a newspaper editorial board;
- placement of your spokesperson on news, public affairs, talk shows, call-ins, or editorial segments;
- paid advertisements; and
- co-sponsorship of events within the community.

Editorial time and space includes:

- letters to the editor; and
- print or broadcast editorials (e.g., on local policies, access to services).

What Makes News

Remember that you are competing with all the other news happening on a given day. Be sure that your story has something extra to offer, such as:

- Widespread interest or interesting angle.
- A local angle.
- Timeliness.
- Human interest.
- Controversy.
- Celebrity involvement.
- Impact on the community.

Note: CDC's two guides, HIV/AIDS Media Relations and HIV/AIDS Managing Issues, provide additional information for working with the mass media. Also, the National Public Health Information Coalition (NPHIC) has prepared a "hands-on" guide for handling media interviews.

Working with the Mass Media

Involve media professionals in planning. Like many other people, they prefer to be involved from the beginning and to feel their opinions are valued, not just their access to media time and space.

Develop a media contact list. The public information office of the state health department probably can get you started. Also, guidance is provided in CDC's Media Relations guide. (See References.)

Establish relationships with the media; concentrate on those media outlets your target population is most likely to see, hear, or read. Articulate a role for media that will contribute to objectives and capture the attention of the target population; build capacity to interact effectively with the news media.

Media relations can be labor intensive. To make sure that the efforts pay off, consider the following:

- Start with a media plan that includes a variety of strategies; coordinate that plan with other program strategies.
- Quickly and competently respond to media queries and deadlines.
- Plan media activities over time, rather than one event at a time.
- Track media results, report successes, and plan for improvement.
- Look for opportunities to turn existing events and stories into new angles to support the media strategy.
- Recognize the contributions of media, e.g., send letters.
- Periodically review what has been accomplished, what needs improvement, and what to do next.

To identify media strategies, consider:

- What has not been covered and could be covered.
- Which media outlets might be interested in doing more.
- Which journalists, columnists, or media personalities might be interested.

Media strategies should:

- Contribute to program objectives.
- Be within your means to accomplish.
- Consider benefits and limitations of business and other partners.

Prioritize media strategies by weighing expected benefits, resources required, and how each could be "sold" to the media. Then, work first on those with the greatest potential. Use information about the public's interest in HIV/AIDS to convince the media to participate.

Assess exposure in the media:

- Quantity -- how much coverage (seconds, column inches) was received.
- Placement -- where the coverage appeared in relation to the target audience's media habits.
- Content -- whether it was likely to attract attention (e.g., with a provocative headline or lead in), favorable, accurate, incomplete, misleading, or negative information.
- Feedback -- whether the target population and/or decision makers in the community responded in a tangible way.

Ways to track media efforts:

- Keep a log of media calls -- track what was said, identify who to call back, identify when coverage will occur; use the log to update media contact lists.
- Clip and review print coverage; tape to review television and radio coverage (purchase videos of coverage from stations or commercial sources when high-quality videos are needed, e.g., for presentations).
- Request from stations a monthly printout that lists when PSAs were shown and the time donated (dollar value).
- Include an audience prompt in messages, and monitor who responds.

Provide media spokesperson training for staff who work with the media. Staff training should also:

- Follow the recommendations in CDC's Media Relations and Managing Issues guides.
- Explore options for working with the media beyond PSAs, including establishing media relationships and message placement.

Other Interventions

This category is used for those interventions that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilization, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Community-level interventions are those that:

1. target the community (often defined by gender, geography, risky behaviors, race, ethnicity, or sexual orientation) rather than a specific individual;
2. involve community members in the actual design and delivery of the intervention; and
3. aim to change community norms about high-risk behaviors (as well as modify individual behaviors)" (Holtgrave et al., 1994).

Programs in this category may use multiple methods in order to influence community norms. These include social marketing (the application of marketing theory and strategies to the promotion of social change), community-based outreach (e.g., using indigenous community members to disseminate information), mass media (television, radio, newspapers, billboards), and small media (newsletters, posters, flyers).

One example of CLI is **Community Mobilization,** the goal of which is to increase awareness and knowledge of HIV/AIDS issues and to provide a foundation for the greater participation of people in general in HIV prevention and service activities. This intervention generally targets persons who are not at risk for HIV/AIDS as well as those who are at risk. Furthermore, community mobilization may not be designed to change individual health behavior; rather, it aims to create a social, political, and institutional climate that is receptive to the development and implementation of effective prevention programs.

An example of Community Mobilization is worksite-based informational seminars designed to dispel myths about HIV/AIDS. This correction of misconceptions may be intended to reduce discrimination against HIV-positive persons or persons whose lifestyle places them at risk for HIV. Another example is that of educational materials directed at parents and members of school boards, the objective of which is to create an environment within which school-based risk-reduction information might be facilitated.

CDC Guidelines for Community Level Interventions

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Community Level Intervention combines community organization and social marketing -- a strategy that takes a systems approach. Its foundation is an assumption that individuals make up large and small social networks or systems. Within these social networks or systems, individuals acquire information, form attitudes, and develop beliefs. Also, within these networks, individuals acquire skills and practice behaviors.

The fundamental program goal of Community Level Intervention is to influence specific behaviors by using social networks to consistently deliver HIV risk reduction interventions. Although the intervention strategy is community-based, Community Level Interventions target specific populations -- not simply the community in general. The client populations have identified shared risk behaviors for HIV infection and also may be defined by race, ethnicity, gender, or sexual orientation.

In order to influence norms that support HIV risk reduction behavior, Community Level Interventions are directed at the population, rather than at the individual. The primary goal of these interventions is to improve health status by promoting healthy behaviors and changing those factors that negatively affect the health of a community's residents. A specific intervention may take the form of persuasive behavior change messages, or it may be a skills-building effort. Whatever its form, an intervention achieves reduced HIV risk by changing group norms to improve or enhance the quality of health for members of the client population. These norms may relate to condom use, contraceptive use, or needle-sharing. They may also focus on diagnosis and treatment of sexually transmitted diseases or HIV-anti

It takes time to change social norms. Social norms cannot be changed quickly or at the same rate that knowledge acquisition or skills development can occur. Change occurs as a result of sustained, consistent intervention efforts over time. The intervention must be implemented thoroughly throughout the social networks. A firm grounding in behavioral theory is essential to the development and implementation of Community Level Interventions.

Community-based needs assessment is critical to the development and implementation of Community Level Interventions. This phase is important for identifying and describing structural, environmental, behavioral, and psychological facilitators and barriers to HIV risk reduction. To successfully conduct this intervention, a program must identify the sources for and patterns of communication within a social network. Peer networks must be defined and described.

Note: Community Level Intervention is referred to as Community Intervention Programs in Program Announcement #300.

The following questions should be considered in designing community level interventions:

- Who are the gatekeepers to the client population?
- What are the important points of access?
- What are the appropriate and relevant risk-reduction messages, methods, and materials?
- What are the linguistic and literacy needs of the client population? A needs assessment should yield this vital information.

A variety of methods exists for collecting the answers to these questions. It is recommended that programs select the method that is most appropriate for their professional orientation (e.g., social work, health education). Whatever method is chosen, it is critical that the formative activity be community-based and as collaborative as possible with the client population.

The information gathered during the formative phase provides the foundation on which an effective program can be built. Completing this activity should result in culturally competent, developmentally appropriate, linguistically specific, and sexual-identity-sensitive interventions that promote HIV risk reduction.

Members of existing and relevant social networks can be enlisted to deliver the interventions. Other peer networks may also be created and mobilized to provide intervention services. This, of course, means volunteer recruitment and management. Community Level Intervention strategies offer opportunities for peers to acquire skills in HIV risk reduction and, in turn, reinforce these abilities when the peers become the teachers of these same skills to others.

In this manner, Community Level Interventions become community-owned and operated; thus, they are more likely to be sustained by the community when the program activity is completed. Social norms changed in this way are likely to have a long-lasting and effective impact upon HIV risk reduction.

HIV Counseling, Testing, and Referral Standards and Guidelines

Centers for Disease Control and Prevention (CDC), May 1994

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OVERVIEW OF HIV COUNSELING AND TESTING

Historical Perspective

Publicly funded HIV antibody counseling and testing services were initiated in March 1985 to provide an alternative to the donation of blood as a means for high-risk persons to determine their HIV status. At that time, little was known about the prevalence and natural history of HIV infection. Counseling was considered an essential adjunct to HIV testing. The counseling addressed the accuracy and consequences of the test and was designed to help persons interpret the meaning of positive or negative antibody results. HIV counseling was based on the recognition that learning HIV status may be difficult for some clients.

In 1987, with increased understanding about the scope and severity of the HIV epidemic and the predictive value of a positive test, HIV counseling and testing were expanded. Persons seeking care for sexually transmitted infections, family planning, childbirth, or substance abuse were counseled and tested in an attempt to reduce their risk for HIV transmission. "The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others." (1)

Since that time, public awareness about HIV infection has increased, and the reliability and predictive value of the HIV test have been proven. Investigations have demonstrated the benefit of early antiviral and prophylactic treatment for HIV infected persons. These HIV counseling standards and guidelines are the result of increased knowledge about HIV prevention and experience with HIV counseling. Counseling is a direct, personalized, and client-centered intervention designed to help initiate behavior change to avoid infection or, if already infected, to prevent transmission to others, and to obtain referral to additional medical care, preventive, psychosocial and other needed services in order to remain healthy.

Goals of HIV Counseling, Testing, and Referral Services

The goals of HIV counseling and testing are to:

- provide a convenient opportunity for persons to learn their current serostatus;
- allow such persons to receive prevention counseling to help initiate behavior change to prevent the transmission or acquisition of HIV;
- help persons obtain referrals to receive additional medical-care, preventive, psychosocial, and other needed services; and
- provide prevention services and referrals for sex and needle sharing partners of HIV-infected persons.

Objectives of HIV Counseling, Testing, and Referral Services

- Identify persons who are unaware, uninformed, misinformed, or in denial of their risk for HIV infection and facilitate an accurate self-perception of risk.
- Prepare clients for and provide them with knowledge of their HIV infection status.
- Negotiate a relevant risk reduction plan and obtain a commitment from clients to reduce their HIV risk.
- Refer clients to resources that will provide psychosocial support and facilitate desired behavior change.
- Provide referral to appropriate drug treatment services for clients whose substance abuse problems enhance their HIV risk.
- Provide information on the increased risk of HIV transmission associated with other sexually transmitted diseases (STDs) and give referrals for STD examination and treatment.
- Provide family planning information and referrals for women of child bearing age who are infected or at high risk for HIV.
- Provide referrals to HIV positive and high risk HIV negative persons for necessary medical, preventive, and psychosocial services.
- Communicate to the client the responsibility for appropriate disclosure including the notification of sex and needle-sharing partners.

Necessary Elements of HIV Counseling, Testing, and Referral Services

- **Maintenance of Confidentiality**

  Strict protection of client confidentiality must be maintained for all persons offered and receiving HIV counseling services.

- **Risk Assessment**

  Risk assessment is the portion of a client-centered discussion that encourages the client to identify, understand, and acknowledge his or her personal risk for acquiring HIV.

- **Prevention Counseling**

  Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. It also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate behavioral risk. Counseling prior to HIV testing (pretest) should prepare the client for receiving, understanding, and managing his or her test result.

- **Providing Test Results**

  Providing HIV antibody test results to a client involves interpretation that is based upon the test result and the client's specific risk for HIV infection. Knowledge of HIV status is important information that a client can use to plan behavior change. Skillful, client-centered counseling is required to reassess behavioral risks which may influence the interpretation of test results. The client will most often focus on the actual result itself rather than behavioral and prevention messages.

- **Provision of Referrals**

  Clients may require referral for physical and psychological evaluations, appropriate therapies (i.e., drug treatment), and support services to enhance or sustain risk reduction behaviors. Each program should maintain complete knowledge of referral resources, including the availability, accessibility, and eligibility criteria for services.

Definitions

These standards and guidelines on HIV counseling were established after consultation between outside experts and Centers for Disease Control and Prevention (CDC) staff. The document is divided into two sections. The first section addresses program level guidance in establishing policies and procedures that are critical to the development and maintenance of an HIV prevention counseling program. The second section describes guidance for counselors and other providers in the approach to and delivery of HIV prevention counseling services. This document will provide two levels of guidance (2):

STANDARDS in this document are intended to be consistently applied to the delivery of HIV counseling and testing services. They must be followed in virtually all cases.

GUIDELINES are intended to be more flexible. They should be followed in most cases. However, they recognize that, depending on the client, setting and other factors, guidelines can and should be tailored to fit individual needs.

These standards and guidelines are intended for persons who provide counseling in connection with HIV testing (3) and encompass the following concepts and terminology:

- **Triage assessment** is the process that determines whether someone should be referred to counseling. Triage assessment facilitates access to prevention counseling services for those persons at increased risk for HIV.
- **Risk assessment** is the process of assisting the client to identify behaviors that place him or her at risk for HIV. The risk assessment should include: reason for visit and other relevant concerns; personal circumstances; the client's resources and support systems; behavioral and other sources of risk; demographic and epidemiologic factors that influence risk; client's awareness of risk, readiness to change behavior, and receptiveness to available services and referrals. An integral component of HIV prevention, risk assessment is not intended solely as a screening tool for client eligibility for HIV testing. The discussion between the client and counselor should result in a negotiated risk reduction plan. The plan must be a realistic, attainable strategy that is developed with the client to achieve behavior changes to reduce the risk for acquiring or transmitting HIV.
- **Client-centered counseling** refers to counseling conducted in an interactive manner responsive to individual client needs. This counseling avoids a preconceived set of points to be made by the counselor and encourages the client to do most of the talking. The focus is on developing prevention goals and strategies with the client rather than simply providing information. An understanding of the unique circumstances of the client is required—behaviors, sexual identity, race/ethnicity, culture, knowledge, and social and economic status.
- **Appropriate disclosure** involves all of the circumstances in which others should be informed of the client's HIV infection status. This determination requires consideration of local and state laws, client confidentiality, and the need to inform others. Disclosure to health care providers and current and subsequent sex and/or drug partners is essential. The client may need guidance and assistance on the methods of informing persons who need to know.

References

(1) CDC. Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS. MMWR 1987;36:509-515.

(2) Eddy, DM. Designing a Practice Policy, Standards, Guidelines, and Options. JAMA. 1990;263:3077-3084.

(3) CDC. Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS. MMWR 1987;36:509-515.

PROGRAM STANDARDS AND GUIDELINES

Client Eligibility Criteria

Public health agencies that receive federal funds from the National Center for Prevention Services (NCPS) are required to routinely offer, on a voluntary basis with informed consent, HIV prevention counseling and HIV laboratory testing services to persons who are potentially HIV infected, their partners and others who have high risk behaviors (1). Grantees are encouraged to offer services to clients at designated counseling and testing sites, sexually transmitted disease (STD) clinics, drug treatment centers, tuberculosis clinics, criminal justice and correctional systems, women's health clinics, youth and adolescent programs, and other sites which serve persons with risk behaviors for acquiring HIV. To use resources as efficiently as possible, grantees are encouraged to integrate HIV counseling and testing into ongoing operations, especially in STD and substance abuse treatment clinics. HIV Prevention Community Planning provides a forum for priority setting, accomplished through a participatory process, which may guide the targeting of HIV counseling services.

Unless it is prohibited by state law or regulation, clients should be offered reasonable opportunities to receive HIV-antibody counseling and testing services anonymously. The availability of anonymous services may encourage some persons at risk to seek services who would otherwise be reluctant to do so.

Grantees who elect to charge for services are strongly encouraged to use a sliding scale, and to provide services regardless of ability to pay. The fact that services will not be denied because of the client's inability to pay should be clearly communicated by the facility by posting signs or providing written materials. Program staff who register clients or collect fees should be familiar with this policy. When a client is identified to be at risk for HIV infection, the health care facility is responsible for providing services or ensuring effective referral for services.

Counseling programs should develop a triage assessment procedure to identify persons at risk for HIV infection. This procedure should consider local circumstances that influence the risk of HIV infection for persons who might not be perceived as being at risk. Health care providers should take advantage of every encounter with a client to reinforce HIV prevention messages (2).

Standards

HIV prevention program managers must accomplish the following:

- Establish systems to ensure that strict confidentiality is maintained for all persons who are assessed for HIV counseling and testing services;
- Seek to ensure that all persons who seek HIV testing are offered counseling relevant to their needs;
- Seek to ensure that persons who are determined to be at risk for HIV infection as a result of sexual or drug using behaviors are routinely counseled;
- Establish that no facility that receives federal funds for HIV counseling and testing services may deny a client services because of that client's inability to pay (3).

Special Considerations

Clients who request repeat testing should be managed as indicated in the "Counseling and Repeat Testing Section."

References

(1) CDC. 1992 HIV Prevention Program Guidance.

(2) CDC. Technical Guidance on HIV Counseling, January 1993.

(3) CDC. 1992 HIV Prevention Program Guidance.

Risk Assessment Development

Program managers, from sites that provide HIV counseling services, should review available data to identify site-specific HIV prevention needs. This review and evaluation should include AIDS case surveillance data, HIV seroprevalence data, STD morbidity, prevention counseling data, and demographic and risk behavior profiles of the population and the catchment community served by each site. Based on analysis of these data, the program should develop policies for each site that address the appropriate provision of primary and secondary HIV prevention services including triage assessment, and targeted or universal risk assessment procedures. For example, if the voluntary HIV testing seropositivity at a site is higher than the blinded seroprevalence, this site may be successfully targeting prevention efforts. However, if the voluntary HIV testing seropositivity is lower than the blinded seroprevalence, this site may not be appropriately targeting assessments, outreach efforts, prevention counseling, and/or provision of voluntary testing services. This information should be used to plan activities and services, redirect efforts and resources to meet current needs, use resources more efficiently, and identify unmet service needs.

Each site that offers HIV testing must provide prevention counseling tailored to individual client needs and should develop an effective method to involve clients in identifying their risk behaviors. This approach should also address local and specific circumstances which might influence the client’s perception of risk. Where available, sites should use triage assessment as one of the first efforts to direct persons at risk of HIV infection into prevention counseling. The clinic environment should support the risk assessment process, by involving clients in identifying their risk behaviors. Strategies to achieve this include group discussions, audiovisual materials, pamphlets, and/or posters. Community based organizations are excellent collaborators in the development and provision of client support services. Educating clients through multiple methods increases the chance that clients will recognize behaviors which place them at risk.

Standards

HIV prevention program managers must make certain that the following are achieved:

- Provision of training and quality assurance to ensure identification of risk behaviors of all clients counseled or tested for HIV;
- Establishment of site-specific demographic and risk profiles, based on analysis of HIV test data;
- Ongoing collection and review of available site-specific data, including AIDS case surveillance data, HIV seroprevalence data, STD morbidity, prevention counseling data, demographic, and risk behavior profiles for targeting of resources and quality assurance of service delivery;
- Determination of appropriate site-specific strategies for risk assessment of clients, based on demographic and risk profiles;
- Procedures to maximize targeting of clients for prevention counseling based on risk profiles.

Guidelines

HIV prevention program managers should do the following:

- Ongoing review and analysis of relevant seroprevalence data, including site specific blinded seroprevalence if available; and
- Analyze, by site, the extent of HIV prevention counseling coverage (number of clients seen, blinded seroprevalence, and number of HIV infected persons identified through prevention counseling).

Referral Service Development

A thorough client assessment often indicates a need for services that cannot be provided by the counselor (e.g. drug treatment, peer support groups, etc.). To ensure that clients receive appropriate care, the program must establish a procedure for referring persons to sites that provide services in a timely, efficient, and professional manner. A collaborative relationship should have already been established with the appropriate representative of the referral site.

Standards

HIV prevention program managers must develop a process for routine referral which include the following:

- A written referral process for identifying, evaluating, and updating referral sources in the site's operations manual;
- A mechanism to provide clients with immediate access to emergency psychological or medical service;
- Appropriate referral resources for;

- Any client at-risk for HIV infection who may be in need of support to maintain safer behaviors,
- HIV negative clients who continue to test but are without risk,
- HIV negative clients who continue to engage in risk behavior,
- HIV positive clients who continue to engage in risk behavior,
- HIV positive or high risk HIV negative clients who need STD diagnosis and/or treatment, and
- HIV positive persons who need a medical assessment.
- Written standards for the follow-up of confidentially tested HIV positive clients who do not return for results and counseling.

Guidelines

HIV prevention program managers should develop a process for routine referral which would accomplish the following:

- Maintains a current list of community and institutional referral resources such as infectious disease specialists and clinics, free clinics, social service agencies, emergency medical services, hospitals, prenatal care clinics, family planning clinics, mental health centers, AIDS service organizations, HIV/AIDS community-based organizations (CBOs), substance abuse treatment facilities, and religious institutions;
- Establishes a liaison at each of these resources; and
- Provides periodic inservices from referral agencies.

Quality Assurance

The objective of quality assurance is to ensure that appropriate, competent, and sensitive methods are used for risk assessments, counseling, and referral of clients. Management staff, contractors, or collaborative agency staff should be trained and able to perform routine objective quality assurance site visits. A minimal level of performance should be determined and agreed upon by the funding agency and the service provider. Less than minimal performance must be remedied, or the site should suspend counseling and testing activities until an acceptable minimal standard of performance can be assured. Counseling programs should develop written quality assurance policies and procedures consistent with these standards and guidelines; these documents should be available to all staff. Client feedback should be routinely used as a factor in assessing the quality assurance of services provided.

Standards

I. Facility

- The site must be geographically accessible to the population it serves.
- The site must operate during appropriate hours and minimize any delay in providing services.
- Counseling rooms must be private to ensure confidentiality of the counseling session.

II. Staff

- Management staff must ensure that necessary resources and systems are available to ensure acceptable job performance.
- The program director must ensure adequate on-site supervision for staff.
- Counselors must meet locally established qualification standards.
- Counselors and other relevant staff must be provided updates at least annually on the scientific/public health aspects of HIV.

III. Educational and Risk Reduction Materials

- Culturally competent, linguistically specific, and developmentally appropriate written HIV information must be available to clients. The National HIV Clearing house is a useful resource to obtain and review a range of HIV education and risk reduction materials.

IV. Records/Forms

- Client records (confidential and anonymous) must contain a copy of the informed consent document, laboratory slip with test results, documentation of prevention counseling, result notification, and formulation of risk-reduction plans.
- Records with patient identifiers must be secured.
- All personal identifying information in connection with the delivery of services provided to any person must not be disclosed unless required by law or unless the person provides written, voluntary informed consent.
- Routine audits of risk assessment questionnaires, counseling and interview forms, and client risk reduction plans must be conducted.

Guidelines

I. Facility

- The physical facility should display a level of professionalism and client orientation relevant to the population served.

II. Staff

- A written job description should be provided for all counselors.

- Performance tasks and standards should be established and reviewed with each counselor.
- All counselor and supervisory staff should be familiar with all services connected with the counseling program.
- New counselors should be observed (with client consent) daily until proficiency is assured and periodically thereafter to ensure that proficiency is maintained.
- The supervisor should routinely provide constructive feedback to the counselor based on observations.
- Case presentations should be conducted routinely, using techniques such as team problem solving sessions with medical, supervisory, and counseling staffs.
- Each counselor and supervisor should be provided additional information through training and/or inservices about HIV, STD, TB, immunization, family planning, substance abuse, and early interventions such as antiviral treatments, etc.

III. Educational and Risk Reduction Materials

- Condoms should be available to the client—directly from providers and easily accessible without the client having to ask.
- Current written materials should be prominently displayed in public areas and made available to clients.
- Current written and audiovisual materials should be culturally and linguistically appropriate for the client population. Materials should be sensitive to the reading levels, gender, and ethnicity of the client population.

Publicly Funded Programs – Data Collection and Analysis

Accurate and consistent data collection of HIV prevention counseling, test results, notification of results, referrals, and partner notification activities are critical to the implementation, maintenance, and evaluation of a quality HIV prevention program. Data collection and quality assurance of referrals and partner notification are addressed in the respective guidelines. Analysis of HIV counseling and testing data in combination with seroprevalence and local demographic and STD morbidity data are essential components of prevention program operations. These data should help:

- Identify barriers and gaps in service delivery,
- Plan, refine and target program intervention strategies,
- Analyze resource allocation,
- Provide site specific feedback to clinic staff, and
- Provide specific feedback to counselors.

Standards

Publicly funded programs must:

- Utilize a standard data collection tool throughout the project area;
- Collect minimum required variables:
    - Unique record/client identifier;
    - Unique site identifier;
    - Prevention counselor identifier;
    - Date of prevention session;
    - Client demographics (age, sex, race/ethnicity, state, county, and zip code),
    - Client risk behavior (identified through client self-assessment and/or counselor discussion with client during prevention counseling);
    - Final laboratory result/report; and
    - Date of notification of results and prevention counseling.
- Adhere to the NCPS site numbering system criteria:
    - Site number is determined by where the client is tested;
    - Each clinic within a facility has a unique site number;
    - Satellite clinics require a unique site number;
    - Site numbers are not duplicated across counties, districts, or parishes;
    - Site location, not counselor identification number, determines the site number; and
    - Counselor/DIS field services and outreach teams require a unique group site number for field work.
- Conduct routine and systematic review of data for errors and inconsistencies and establish formal mechanisms for corrections.
- Report client record data (with client identifiers removed) to NCPS on a quarterly basis.
- Use the following program indicators to assess HIV testing at individual sites:
    - Number of clinic visits,
    - Number of clients eligible for prevention counseling,
    - Number of clients who received prevention counseling,
    - Number of clients tested for HIV,
    - Number of clients testing positive,

- Number of positive clients notified of results and provided prevention counseling,
- Number of clients testing negative,
- Number of negative clients notified of results and provided prevention counseling, and
- Other relevant program indicators identified through ongoing quality assurance and data analysis.

Note 1: The first three indicators provide important denominator data for sites that provide a range of health care services.

Note 2: Ongoing consultations are planned and may alter data collection and data analyses standards.

Guidelines

Publicly funded programs should:

- Review site-specific data analysis with appropriate staff at least quarterly.
- Conduct counselor-specific data analysis and provide feed back to the counselor at least twice a year.
- Conduct personnel resource analysis to establish minim u m workload guidelines.
- Establish a computerized data system to facilitate data analysis for quality assurance.

Counselor and Provider Standards and Guidelines

Risk Assessment

Risk assessment—an integral component of HIV prevention counseling—is based on the premise that certain behaviors increase risk for infection with HIV. The counselor should engage the client in a discussion which enables the client to recognize and accept personal risk for HIV. Because the risk-assessment process serves as the basis for assisting the client in formulating a plan to reduce risk, it is an essential component of all pretest counseling.

When the counselor assesses a client's risk or reviews risk information previously recorded by the client or a clinician, the approach should be thorough and individualized for each client. The counselor should accept that the client's disclosures concerning risk behaviors correspond to his or her readiness to initiate behavior change. Each counselor should develop effective interactive methods to involve the client in identifying risk behaviors.

Standards

- Assure the client that test results and other information he or she provides will remain confidential.
- Determine the client's prevention and clinical needs by engaging him/her in a discussion that addresses: client's reason for visit and other relevant concerns; other personal circumstances; client's resources and support systems; behavioral and other sources of risk, demographic and epidemiologic factors that influence risk; client awareness of risk; readiness to change behavior; and receptiveness to available services and referrals.
- Listen for and address, as appropriate, information such as the following:
    - Number of sex partners (casual and steady) and sexual activities including vaginal, anal, and oral sex, both receptive and insertive activities;
    - Sex with a person known to be HIV-positive;
    - Sharing needles or having sex with persons who share needles;
    - History of STDs and having sex with persons who have STDs, especially genital lesions;
    - Assessment of current STD symptom status;
    - Sex in exchange for drugs, money, or other inducements;
    - Use of substances such as alcohol, cocaine, etc., in connection with sexual activity;
    - History of HIV antibody testing and results;
    - Condom use; and
    - Birth control—pregnancy prevention methods.

- Document acknowledged risk behavior, decisions about testing, and negotiated risk reduction plans in the client's record.

SPECIAL CONSIDERATIONS

- Risk assessment information may also be obtained by:
    - the clinician during the sexual/drug/medical history prior to or as a component of the counseling session;
    - utilizing a risk assessment tool completed by the client prior to the counseling session.

HIV-Prevention Counseling

Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate the risk. Counseling prior to HIV testing, prevention counseling (pretest counseling), should prepare the client to receive and manage his or her test result. Prevention counseling should also: 1) facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial; 2) translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status; 3) help clients initiate and sustain behavior changes that reduce their risk of acquiring or transmitting HIV. Unless it is prohibited by state law or regulation, clients should be offered reasonable opportunities to receive HIV-antibody counseling and testing services anonymously. The availability of anonymous services may encourage some persons at risk to seek services who would otherwise be reluctant to do so.

Standards

- Assure the client that test results and other information he or she provides will remain confidential.
- Discuss anonymous testing options.
- Provide client-centered counseling to:
    - Establish and/or improve the client's understanding of his/her HIV risk;
    - Assess the client's readiness to adopt safer behaviors by identifying behavior changes the client has already implemented; and
    - Negotiate a realistic and incremental plan for reducing risk.
- Discuss clients history of HIV testing and results.
- Involve the client in an assessment to determine his or her behaviors which result in a risk of acquiring HIV infection.

- Tailor the counseling session to the behaviors, circumstances, and special needs of the client.
- Assist the client in recognizing those behaviors which put him or her at risk for HIV.
- Identify steps already taken by the client to reduce risk and provide positive reinforcement.
- Identify barriers/obstacles to the client's previous efforts to reduce risk.
- Determine one or two behavioral changes the client may be willing to make to reduce risk.
- Discuss the steps necessary to implement these changes.
- Address any difficulties the client anticipates in taking these steps.
- Respond to the client's concerns.
- Provide the client with necessary referrals and a written copy of the risk reduction plan (this plan should not include any personal identifiers). For clients who cannot read, a verbal summary should be provided.
- Assist the client to arrive at an appropriate decision concerning HIV testing.
- Obtain informed consent from the client prior to testing.
- Establish a plan with the client to receive test results.

Guidelines

- Document the risk assessment in the client's record for use during subsequent care.
- Document the risk reduction plan in the client's record.
- Ensure that the client understands the risks and benefits of knowing his or her HIV infection status.
- Discuss the client's expectations of test results.
- Discuss the client's plan to cope while waiting for test results.
- Explore with the client support systems that may be available.
- Ensure that the client understands what will happen during his or her visit to receive test results.
- Discuss the client's responsibility to disclose HIV infection status to sex/needle sharing partners.

SPECIAL CONSIDERATIONS

As part of the assessment, the counselor should ascertain the client's understanding of HIV transmission and the meaning of HIV antibody test results. When appropriate and relevant to the client, the counselor may:

- **Discuss what the virus is and how it is transmitted.** Assist the client to comprehend transmission of HIV and the delay between infection and development of a positive test.
- **Discuss what the test results mean and how they are used in medical management.** Negative Result - A negative test means that the person is either (1) not infected, or (2) so recently infected that the test could not detect the infection. Positive Result - A positive test means that the person is infected with HIV and can transmit it to others.
- **Discuss need for retest.**
  Clients engaging in continued high-risk behavior should be retested 6 months after the last possible exposure to any HIV risk. (See "Counseling and Repeat Testing" Section.)
- **Review risk reduction options with the client, for example:**
  - Abstain from sex and injecting street drugs; enroll in a drug treatment program.
  - Practice mutual monogamy between two HIV nega tive persons.
  - Use condoms to prevent STDs and HIV transmission.
  - Modify sexual practices to low or no risk behaviors.
  - Limit the number of sex partners.
  - Disinfect drug injecting equipment and avoid sharing paraphernalia.
- **Advise persons with behavioral risk for HIV not to donate blood and not to use the blood bank as a means of periodic HIV testing.**
- **Discuss related healthy behaviors, for example:**
  - Limit the use of alcohol and other drugs.
  - Obtain family planning assistance, when appropriate.
  - Obtain early diagnosis and treatment for STDs, when appropriate.
- **Explain authorized disclosures and antidiscrimination protection.**
- **Discuss bringing a support person of the client's choice, at the time of receiving test results.**

Notification of HIV Results and Prevention Counseling

Providing HIV antibody test results to a client involves interpretation that is based on the test result and the person's specific risk for HIV infection and dealing with the client's reaction to his/her test result. The client will most often focus on the result itself. Client-centered counseling is required to reassess behavioral risk that may influence the interpretation. When the client receives HIV test results, the primary public health purposes of counseling are (1) to reinforce perception of risk for those who are unaware or uninformed; (2) to help uninfected persons initiate and sustain behavior changes that reduce their risk of becoming infected; (3) to arrange access to necessary medical, prevention, and case management services for persons with a positive test

result; (4) to assist those who may be infected to avoid infecting others and remain healthy; and (5) to support and/or assist infected clients to ensure the referral of as many sex or needle sharing partners as possible.

Knowledge of HIV status is an important piece of information a client can use in planning the scope of behavioral changes. Persons who abstain or have sexual relations with others who are known to be free of HIV infection and who do not use injecting drugs can essentially eliminate their risk of acquiring HIV. However, the consistent and correct use of condoms or the adoption of certain non-insertive sexual activities can greatly reduce the risk of acquiring or transmitting HIV. Although methods may be employed to reduce the risk of HIV from injecting drug use (such as the use of new needles), injecting drug use constitutes a health risk even in the absence of HIV and must be avoided.

The risk assessment and risk reduction plan developed during counseling prior to HIV testing provide a framework for strengthening efforts the client has already taken toward healthier behaviors and for recommending modifications based upon the HIV test result.

Standards

- Review available documentation including the risk assessment, prior to meeting with the client.
- Assure the client that test results and other information he or she provides will remain confidential.
- Provide HIV positive test results only by personal contact, assuring a confidential environment.
- Provide counseling at the time results are given to:
    - Assess the client's readiness to receive HIV test results;
    - Interpret the result for the client, based on his or her risk for HIV infection;
    - Ensure that the client understands what the result means and address immediate emotional concerns; and
    - Renegotiate or reinforce the existing plan for reducing risk considering the client's HIV status.
- Discuss with the client the need to appropriately disclose HIV status.
- Assess the client's need for subsequent counseling or medical services.
- Develop a plan to access necessary resources and appropriate referrals.
- For use during subsequent clinical care, document test results, risk reduction plan, and identified need for any resources and referrals in the client's chart.
- Ensure that confidentially tested HIV infected clients who do not return for results and counseling are provided appropriate follow-up. Document all follow-up. Exhaustive efforts

should be made to ensure that confidentially tested HIV infected clients are offered their HIV test results and counseling.

Interpretation of HIV antibody test results depends upon the client's risk behaviors. Some recently infected clients may have negative antibody tests. Indeterminate results may represent a recent HIV infection or a biologic false positive. Eliciting specific information about recent risk behavior is essential to accurate interpretation and counseling.

The client will likely encounter circumstances where it is appropriate to reveal their HIV infection status (e.g., to health care or dental providers; past, present, or potential sex and needle sharing partners). It is important to discuss such situations with the client and assist in developing a plan and skills for appropriate disclosure of HIV infection status.

Guidelines

I. Negative HIV Test Result

- Ensure that the client understands what the test result means including:
    - Limitations of test (i.e., time lag between infection and development of antibodies); and
    - Need for periodic retesting if the client partici pates in risk behaviors.
- Identify any steps already taken by the client to reduce risk and provide positive reinforcement.
- Encourage the client to continue avoiding risk behaviors.
- Determine one or two behavioral changes the client may be willing to make to reduce risk and discuss steps to implement these changes.
- Assist the client in building skills to negotiate risk reduction activities with current or potential partners through discussion and role plays.
- Offer referral for further assistance in avoiding risk behaviors and maintaining low-risk behaviors.
- Discuss his/her need and ability to help partners realize they are also at risk for HIV infection.
- Reinforce the importance of discussing risk reduction measures with potential partners; identify any difficulties the client perceives.
- Advise client about importance of early STD detection and treatment to reduce HIV risk.
- Advise client to refrain from donating blood, plasma, and organs.
- Advise client on access to other prevention and treatment services (i.e., drug treatment, psychosocial support, etc.)

II. Positive HIV Test Result

Some HIV positive clients may be better prepared to receive positive test results than others. Counseling of patients with positive results must be directed to the client's specific circumstances and may require more than one session. Counselors should recognize that the emotional impact of learning about an HIV positive test result often prevents clients from absorbing other information during this encounter. Counselors may need to arrange additional sessions or provide appropriate referrals to meet the client's needs and accomplish the goals of counseling persons who are HIV positive.

- Allow time for the client's emotional response after learning his or her positive HIV result. A subsequent counseling session or follow-up telephone call may be required.
- Ensure that the client understands what the test result means.
- Assess the client's immediate needs for medical, preventive, and psychosocial support. (e.g., financial, personal, and other)
- Make the client aware of the need for additional medical evaluation and the availability of treatment.
- Establish a plan for continuing medical care and psychological support, including a subsequent prevention counseling session if necessary. As part of the plan, the counselor should:
    - Identify necessary referrals and assist the client with contacting them, and
    - Provide the client with written referral information.
- Reassess the client's risk for transmitting HIV infec tion.
- Help facilitate behavior change and/or reinforce behaviors that minimize or eliminate risk of transmission.
- Discuss with the client access and availability to ongoing prevention services including psychosocial and support services.
- Discuss with the client the responsibility to assure that sex and/or needle-sharing partners are counseled about their exposure to HIV and the need for them to seek medical evaluation.
- Assist the client in developing a plan which ensures that all partners are counseled about their exposure to HIV.
- Discuss how the client will notify other persons of his or her HIV status including future sex and needle-sharing partners, health care providers, and dental providers.
- Discuss with the client his or her specific plans for the next few days and ensure that the client has access to support systems during this time.
- Advise client to refrain from donating blood, plasma, and organs. The current testing strategy of two EIA determinations followed by a supplemental test for confirmation, such as the Western blot, makes false positive test results extremely unlikely; however,

the possibility of a mislabeled sample or laboratory error must be considered, and for a client with no identifiable risk for HIV infection, a repeat test may be appropriate.

SPECIAL CONSIDERATIONS

- Clients whose results are HIV positive may have specific medical questions. Considering the complexity of medical questions, responses should be left to clinicians to whom the client is referred, or to counselors or case managers with specific expertise in this area.
- Some clients may be at very high risk of transmitting the virus to others. Sites are encouraged to provide, either on-site or through referral, additional prevention counseling (individual, couple, group, or peer), as appropriate to the needs of these clients.
- Counselors should appreciate the complexity of reproductive decision-making for HIV-infected women and must be familiar with the most recent Public Health Service recommendations on antiretroviral therapy to prevent vertical transmission. (1)

III. Indeterminate Test Result

- Explain that the test result is inconclusive and may represent either:
    - a biologic false positive test, or
    - a truly positive test from a recent infection in which antibodies have not yet fully developed.
- Schedule a repeat test approximately 6 weeks after the date of this inconclusive test
- Emphasize that the client must take the same risk reduction precautions as persons testing HIV positive until the indeterminate finding is resolved.
- Assess the client's concerns and anxieties during the waiting period. If necessary,
    - arrange psychological referral to assist the client with coping while resolving the indeterminate test result,
    - provide a hotline telephone number(s) as a referral option, and
    - provide a subsequent counseling session or follow-up telephone call.

Counseling and Repeat Testing

Situations where clients need repeat HIV counseling or request repeat HIV testing challenge and pose difficult issues for counselors. These situations include previously counseled persons who continue to place themselves or others at risk for infection, persons with indeterminate test results, seronegative persons with no risk who continue to request testing, and persons doubting or

disbelieving their seropositive test results. Repeat testing is not advised as a substitute for initiating and maintaining safer behaviors.

Standards

- Assess the reasons the client requests repeat testing or continues risk behaviors.
- Emphasize that repeated testing for HIV will not prevent infection if the client continues to engage in risk behaviors.
- Arrange the specific services to meet the client's needs.
- Document all counseling activities, negotiated plans, and referrals in the client's record.

Guidelines

I. Persons with Continued Risk — Previous HIV Test Negative

The counselor should:

- Review previous risk assessment and risk reduction plan with client.
- Proceed with HIV counseling as outlined in the Section, "HIV Prevention Counseling."
- Provide alternative counseling options (e.g. referral to community based group or individual counseling) to the client to further help him or her understand his or her recidivist risk behavior(s) and modify the behaviors accordingly.
- Acknowledge incremental behavior changes, reinforce those which have reduced risk, and document in the client's chart.
- Identify obstacles that the client encountered in adopting safe behaviors.
- Explain potentially negative impact of HIV reinfection or exposure to other STDs.

II. Persons with Continued Risk—Previous HIV Test Positive

- Explain the continued risk of infecting sex and needle sharing partners.
- Negotiate a plan with the client to prevent HIV transmission.
- Identify resources and alternative counseling options to ensure that the client implements this plan and to reinforce the importance of practicing safer behaviors to protect himself or herself and others.
- Reinforce the importance of informing partners and making risk-reduction decisions with partners.
- Ensure that the client understands the adverse impact of STDs and drug use upon immune function.

III. Persons with Indeterminate Test Results

The counselor should:

- Arrange a repeat test approximately 6 weeks from the date of this current test;
- Assess the client's concerns and level of anxiety during the waiting period. If necessary, arrange psychological referral to assist the client in coping;
- Consider persons to be negative for antibodies to HIV if their Western Blot test results continue to be consistently indeterminate for at least 6 months in the absence of any known risk behaviors, clinical symptoms, or other findings (2);
- Encourage the client to follow guidelines outlined in the "Notification of HIV Results and Prevention Counseling Section."

IV. Persons with No Risk—Negative Test Results

The counselor should:

- Counsel the client on modes of HIV transmission and behaviors that place persons at risk for HIV;
- Counsel the client on unwarranted fears;
- Arrange referral for additional counseling for clients who continue to exhibit unfounded anxiety about HIV.

V. Persons Who Doubt Previous Seropositive Test Results

The counselor should:

- Assess why the client doubts the accuracy of the test results;
- Explain the process of multiple tests to confirm a positive result;
- Assist the client in recognizing behaviors that lead to HIV infection.
- For clients with no acknowledged risk for HIV, repeat the test.
- For clients with behavioral risk for HIV, arrange for medical referral and repeat test, if necessary.

REFERENCES

(1) CDC. Zidovudine for the Prevention of HIV Transmission from Mother to Infant. MMWR, 1994;43(16):285- 287.

(2) CDC. Interpretation and use of the Western Blot Assay for Serodiagnosis of Human Immunodeficiency Virus Type 1 Infections. MMWR, 1989;38(S-7):1-7.

Referral Process

A thorough client assessment often indicates a need for services that cannot be provided by the counselor. The counselor has two opportunities to make referrals: (1) the HIV prevention counseling session, and (2) the test notification/prevention counseling session.

Standards

- Provide appropriate referral resources for:
    - Any client who may be in need of support to maintain safer behaviors,
    - HIV negative clients who continue to engage in risk behavior,
    - HIV negative clients who continue to test but are without risk,
    - HIV positive clients who continue to engage in risk behaviors, and
    - HIV positive clients with additional medical, social, or psychological needs.
- Provide the client with a written list of referrals including telephone numbers, addresses, hours of operation, and services provided.
- Document referrals in the client's record. Referrals made during the initial HIV prevention counseling session should be followed-up during the test notification/prevention counseling session.

Guidelines

The counselor should:

- Offer referral to case management provider, if one is available;
- Seek feedback from the client about preferences for referrals, the accessibility of the referral, and the client's intention to follow through with the referral;
- Provide the client with relevant details about referral sites, e.g., the name of a specific contact person.

SPECIAL NOTE

Any HIV positive or negative client who continues to engage in risk behaviors should know where and how to access STD examination and treatment services.

TERMS USED IN HIV PREVENTION

ABSTINENCE: Refraining from participating in something. When talking about HIV, abstinence refers to not engaging in sexual intercourse or injecting drugs.

AIDS: The acronym for acquired immunodeficiency syndrome. AIDS can affect the immune and central nervous systems and can result in neurological problems, infections, or cancers. It is caused by HIV.

ANAL SEX: A type of sexual intercourse in which a man's penis enters his partner's anus.

ANONYMOUS: Without any identification. The term is used in regard to HIV testing when the persons ordering and performing the test do not maintain a record of the name or identity of the person whose blood they are testing.

ANTIBODIES: Proteins that are manufactured by the immune system in response to foreign substances.

ANTIBODY TEST: A laboratory procedure which detects antibodies to specific microorganisms. An HIV antibody test determines if a person's body has produced antibodies to HIV but does not detect the virus itself.

ANTIDISCRIMINATION PROTECTION: Provisions of laws that impose penalties for discrimination because of a person's HIV infection or perceived risk of infection.

ANTIVIRAL: Pertaining to something that inhibits the actions of a virus. Antiviral therapy refers to a treatment that works against the virus itself.

ANUS: The opening of the body through which feces or bowel movements pass. The anus is the part of the body which is penetrated during anal sex.

APPROPRIATE DISCLOSURE: Notifying specific people of a client's HIV risks or infection to other people because of their risk of exposure or their ability to provide medical assistance or support.

ASYMPTOMATIC: Being infected but having no symptoms of infection. BISEXUAL: A person whose sex partners are both men and women. A bisexual can be a man or a woman.

CD4 TESTING: A laboratory blood test that counts a subset of white blood cells as an aid to determining immune function. Certain counts are indications for starting medications for persons with HIV infection.

CLIENT: A person to whom professional services are rendered.

CLIENT-CENTERED APPROACH: Refers to counseling conducted in an interactive manner responsive to individual client needs. Avoids a preconceived set of points to be made by the counselor and encourages the client to do most of the talking. Focuses on developing goals with the client rather than simply providing information or imposing counselor goals.

CONDOM: Commonly called rubbers, condoms are sheaths that fit over a man's penis or into a woman's vagina to prevent semen from entering the partner's body after ejaculation. Condoms also prevent a man's penis from coming in contact with his partner's body fluids.

CONFIDENTIAL: Kept private. In regard to HIV testing, it means that the results of a test are known only to the person who is being tested and the immediate group of people who provide care and prevention services for that person.

COUNSELING: Helping people plan actions that will benefit themselves or others. Unless designated as group counseling or couple counseling, the word is used here to describe one-on-one discussions.

DISCORDANT: Conflicting. Used to describe the circumstances in which one partner is infected with HIV and the other is not.

EIA: See ELISA.

EARLY INTERVENTION: The set of medical, preventive and psychosocial services provided to persons upon diagnosis of HIV infection. Involves monitoring indicators of immune function as signals to provide interventions to delay the onset of illness, psychosocial support, and measures to prevent transmission.

ELISA: Acronym for enzyme-linked immunosorbent assay. The laboratory test most commonly used to screen for antibodies to HIV. See Positive Test.

FALSE-NEGATIVE: A negative test result for a person who is actually infected.

FALSE-POSITIVE: A positive test result for a person who is actually not infected.

HETEROSEXUAL: A person whose sex partners are exclusively persons of the opposite sex.

HIV: Human immunodeficiency virus; the virus that causes AIDS.

HOMOSEXUAL: A person whose sex partners are exclusively members of the same sex. A homosexual man is called a gay man. A homosexual woman is called a lesbian.

IMMUNE STATUS: The state of the body's natural ability to fight diseases.

IMMUNE SYSTEM: The body's mechanism to identify and fight off infections and other foreign substances.

INJECTED DRUGS: Drugs that are introduced directly into a person's body or bloodstream through a needle. These include cocaine, crack, heroin, and steroids.

INDETERMINATE: Not determined one way or another. Inconclusive test results; the laboratory is unable to state whether antibody is present or not.

INTERVENTION: An action taken to change an outcome.

MASTURBATION: Stimulating a man's penis or a woman's clitoris.

MONOGAMOUS: Having an exclusive sexual relationship with only one partner. Mutual monogamy means neither partner has sex with other people.

MORBIDITY: Illness or disease.

MORTALITY: Death.

NEGOTIATED RISK REDUCTION PLAN: Discussions that result in identifying the steps that a client thinks he or she will take to reduce the chances of acquiring HIV. The counselor's role is to assist the client in developing a realistic plan.

OUTREACH SERVICES: Usually refers to services provided outside the walls of an agency. An outreach worker might go to a client's home or neighborhood.

PARENTERAL: Taken into the body through intravenous or intramuscular injection.

PHLEBOTOMY: Collecting a blood sample for laboratory testing by inserting a needle into a person's vein.

POSITIVE REINFORCEMENT: Acknowledging healthy behaviors or intentions through some mechanism that indicates approval, intended to be perceived as rewarding.

POSITIVE TEST: For HIV, a sample of blood that is reactive on an initial ELISA test, repeatedly reactive on a second ELISA run on the same specimen, and confirmed positive on Western blot or other supplemental test.

PREVALENCE: The total number of persons in a given population with a disease or condition at a given point in time.

PREVENTION COUNSELING: Counseling which is designed to facilitate the client's perception of risk, identify behavior changes that the client has already implemented and barriers to the client's previous efforts to reduce risk, and to assist the client in developing a plan to reduce risk regardless of whether or not he or she takes the test. Prevention counseling that takes place prior to HIV testing should prepare the client for receiving and managing his or her test results.

PROBLEM-SOLVING TECHNIQUES: A process by which a counselor tries to discover the basis of barriers indicated by some verbal or nonverbal communication from the client. After the barriers have been identified, possible solutions are discussed.

PROPHYLACTIC TREATMENT: Medications given to help prevent infection or its consequences.

RETROVIRUS: One of a group of RNA viruses. HIV is a retrovirus.

RISK ASSESSMENT: Used in this document, risk assessment is that portion of a client-centered discussion that encourages the client to identify and acknowledge his or her personal risk for acquiring HIV.

SENSITIVITY: The probability that a test will be positive when infection is present.

SPECIFICITY: The probability that a test will be negative when the infection is not present.

SPERMICIDE: A substance that kills sperm.

TRIAGE ASSESSMENT: The process that determines whether someone should be referred to counseling. Triage assessment facilitates prevention counseling services for those persons at increased risk for HIV.

WESTERN BLOT: A laboratory test that detects specific antibodies to components of a virus. Often used to confirm HIV antibodies in specimens found repeatedly reactive using the ELISA test for HIV antibodies.

DISTRICT OF COLUMBIA HIV COUNSELING AND TESTING POLICY

October 1999

BACKGROUND

Acquired immune deficiency syndrome (AIDS) has become one of the major health problems in the District of Columbia and across the nation. As part of the District's comprehensive program to combat AIDS, an extensive AIDS education program has been developed to prevent further transmission of the disease. A major component of this program is the provision of voluntary human immunodeficiency virus (HIV) antibody counseling and testing services by the Department of Health. These services are provided on both a confidential and anonymous basis.

THE TEST

The HIV antibody test detects the presence of antibodies in the body. The test was originally made available to protect the nation's blood supply by screening donated blood. The test has since been made available on a much wider basis, enabling individuals to learn their antibody status.

The HIV antibody test is not a test for AIDS. The test does not tell if a person has or ever will develop AIDS or any AIDS-related condition. The test does show whether a person has been infected with the virus known to cause AIDS.

The Department of Health provides HIV antibody testing for individuals interested in knowing their antibody status when deemed necessary as part of a medical evaluation; as an alternative to using blood banks to obtain antibody status; and for research purposes.

ANONYMOUS TESTING

Anonymous testing is designed to ensure that the identity of a person taking the test is not associated with the test or the results. A person requesting anonymous testing is not identified by name, but by a code. Anonymous testing is available at several alternative test sites on a walk-in or appointment basis.

Procedures for Anonymous Testing

1. Patients must receive explanation of procedures used for anonymous testing and availability of confidential testing.
    - No names are used;
    - No record of test result;
    - Blood tests submitted to laboratory anonymously using seven-digit initial date of birth codes; and
    - Client must return in person for results
2. Patients must receive prevention (pre-test) counseling providing:

- Information about what the HIV antibody test is;
- Assessment of risks for HIV-infection;
- Explanation of what the test results mean and limitations of the test results;
- Prevention/risk reduction information; and
- Incremental risk reduction plan.

3. Test results must be given in person:
    - Test results will only be communicated to the patient in person during a pre-arranged post-test (post-test) counseling session;
    - Under no circumstances are test results ever to given out over the telephone or through the mail.
    - Positive test must be verified by a repeat Elisa test, and if still positive, confirmed by Western Blot analysis before patient is told of results; and
    - Written verification of test results will be provided to the client with their written consent.
4. Patient must receive post-test counseling:
    - All patients will be counseled about the meaning of test results and appropriate prevention/harm reduction measures;
    - All individuals testing positive will be counseled about spousal/partner notification of their antibody status. The law requires that a provider "must make a reasonable effort to notify any individual who is the marriage partner of an HIV infected patient, or who has been the marriage partner of that patient at any time within the 10 year period prior to the diagnosis of HIV infection." The Department of Health provides "Partner Notification Services." Partner Notification shall be conducted in accordance with the Centers for Disease Control and Prevention Guidance dated October 1998.
    - All individuals will be counseled to inform their health care providers of their antibody status.
    - Referrals for Case Management and or Primary Medical Services will be made when appropriate.

CONFIDENTIAL TESTING

Confidential testing occurs when the identity of the individual is known to the health care provider, but the results of the HIV test will not be disclosed except in accordance with the consent form signed by the patient. Confidential testing will be offered by persons who have a history of high-risk behavior, persons with clinical signs and or symptoms of HIV, and persons who request the test.

1. Patient/Client must receive an explanation of procedures used for confidential testing:
    - Written informed consent required;
    - Test results become part of patient's medical record and maintained in a confidential manner.
2. Patient/Client must receive pre-test counseling providing:
    - Information about what the HIV antibody test is;
    - Assessment of risks for HIV-infection;
    - Explanation of what the test results mean and limitations of the test results;
    - Prevention/risk reduction information; and
    - Incremental risk reduction plan.
3. Patients must give informed consent in writing after the informed consent form is explained:
    - Antibody test will not be given without written consent;
    - Consent form and test results will be placed in the patient's medical record and maintained under strict security.
4. Test results must be given in person:
    - Test results will only be communicated to the patient in person during a prearranged post-test (post-test) counseling session;
    - Under no circumstances are test results ever to given out over the telephone or through the mail.
    - Positive test must be verified by a repeat Elisa test, and if still positive, confirmed by Western Blot analysis before patient is told of results; and
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5. Patient must receive post-test counseling:
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    - All individuals will be counseled to infonn their health care providers of their antibody status.

- Referrals for Case Management and or Primary Medical Services will be made when appropriate.

FEES

Confidential services at the S.E. Sexually Transmitted Disease Clinic, TB Clinic, Addiction Prevention & Recovery Administration, AHA grant/contract funded programs, and Public Benefit Corporation Health Clinics staffed by AHA counselors', are provided free in the public interest. There will be no charge for HIV counseling & testing services at these locations.

POLICIES FOR PROTECTION OF CONFIDENTIALITY

All medical records, laboratory reports and consultation reports are to be maintained in a confidential and secure manner. No such data are to be left unattended. When not required by staff, all such data are to be kept in locked files or locked rooms, which are not accessible to nonstaff members. Clinic/Program managers will be ultimately accountable for security of medical records and reports.

Any employee who is found guilty of violating the confidentiality of said medical records, reports, or related data would be disciplined in accordance with established personnel policy.

Written informed consent is required prior to HIV testing and will state that results of the HIV test bell be recorded in the patient's medical record. The medical record is available for review by appropriate clinic staff when necessary to receive medical services.

SUBMISSION OF LABORATORY SPECIMENS

All HIV blood samples, whether obtained through anonymous or confidential, will be submitted to the servicing laboratory using the first and last initials, and 6-digit date of birth of the person being tested. Laboratory specimens or lab slips will not have the name of the person being tested attached to them. Example (JD01 1052) John Doe date of birth January 10, 1952.